SHC Clemsfold Group Limited

Horncastle Care Centre

Inspection report

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12 February 2020
13 February 2020
21 February 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service

Horncastle Care Centre is a residential care service that provides nursing and personal care for 10 people and younger adults with learning disabilities or autistic spectrum disorder, physical disabilities, acquired brain injury and neurological disabilities at the time of the inspection. There were three people who also regularly received respite care at the service each week. The service can support up to 20 people.

The service is larger than current best practice guidance and consisted of two separate bungalows, Maple Lodge and Willow Lodge. The service was in private grounds in the countryside. Both bungalows were bigger than most domestic style properties. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of each bungalow to indicate it was a care home. Staff wore uniforms and name badges to say they were care staff when coming and going with people.

Horncastle Care Centre is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation in relation to incidents that occurred between 2016 and 2018. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found

Horncastle Care Centre had been built and registered before the Care Quality Commission (CQC) policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published and is larger than current best practice guidance.

The guidance and values included in the RRS policy advocate choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; People did not always receive personalised care. People did not always plan, review or develop their individual support needs and wishes. People did not always have support with meaningful activities. People's communication needs were not always met.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the

service did not always support this practice.

Risks to people with epilepsy, constipation and behaviours that may challenge were not always adequately assessed, monitored and managed, causing or exposing people to risk of harm. People had not received medicines as intended when required and medicines had not always been stored safely.

Staff practice and reporting systems to safeguard people from abuse were not always effective. Lessons were not always learnt, and actions taken to investigate safety incidents and prevent them re-occurring.

Service management and the provider's wider quality assurance and governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Horncastle Care Centre.

The provider had not ensured that staff at all levels understood their responsibilities and managed staff accountability effectively. Statutory notifications had not always been submitted when required. he provider had not always shared information openly and honestly with partnership agencies.

Staff did not always have the right skills, knowledge or experience to deliver effective care to people. People's day to constipation and epilepsy needs were not always met and staff were not always monitoring people's health and well-being needs effectively.

People had support to have their nutritional needs met and had enough to eat and drink. There were safe recruitment practices. The premises had been designed to accommodate people's needs.

People told us that staff acted with compassion and responded to their emotional well-being in a meaningful way. We observed positive examples of staff interacting with people in a caring manner. One person told us they liked living at the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

We last inspected this service on 28 and 29 August 2019. The service was rated Inadequate (Published 3 December 2019). The service remains rated Inadequate. The service has been rated Inadequate for the last three consecutive inspections.

This service has been in Special Measures since May 2019. At this inspection not enough improvement had been made and the provider remains in special measures.

Why we inspected

This was a planned inspection based on the previous rating. After the visits on 12 and 13 February 2020 we received further specific concerns about risks to people with epilepsy support needs. The visit on 21 February 2020 was prompted by those concerns.

Enforcement

At this inspection, we have identified six continued breaches of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 regulations 9, 11, 12, 13, 17 and 18 in relation to: person centred care, safe care and treatment, consent, safeguarding people from abuse, good governance and staffing. We have also identified that the provider has not notified CQC in relation to other incidents as required. This is a breach of CQC (Registration) Regulations 2009 regulation 18.

In December 2018 we imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at several services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The provider's appeal to the Notice of Decision was withdrawn in June 2020 and the enforcement action to remove the registration of this location took effect. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Horncastle Care Centre

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection took place over three days on 12, 13 and 21 February 2020.

On 12 February 2020 the inspection team consisted of three inspectors, a registered nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On 13 August 2020 the inspection team consisted of three inspectors and a registered nurse specialist advisor.

On 21 February 2020 the inspection team consisted of one inspector.

Service and service type

Horncastle Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of the inspection, the registered manager had been absent from managing a regulated activity at

the service for more than 28 consecutive days.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals.

We looked at any safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all this information to plan our inspection.

During the inspection-

During the inspection we spoke with six care staff, three registered nurses, the activities assistant, the manager, the Clinical lead, the Safeguarding lead and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We 'pathway tracked' five people using the service. This is where we looked at people's care documentation in depth and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We spoke with three people using the service and observed people's support across all areas of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with one relative of a person who was visiting the service.

We reviewed staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records.

We also reviewed quality audits, policies and procedures, staff rotas and information about activities people were supported with and provided by the service.

After the inspection –

We asked the provider to send us information to clarify and confirm evidence found at the inspection site visit.

We requested assurances via a formal letter about actions the provider would take to ensure that risks related to people's epilepsy support needs were managed safely.

We asked for information and feedback from health and social care professionals who had been working with staff and people at the service from the local authority and Clinical Commissioning Group.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, learning lessons when things go wrong, using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and learn lessons and make improvements when things go wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management

●Risks to people with epilepsy were not always being monitored, assessed or managed safely, exposing them to high risk of harm.

●There were inconsistencies in people's seizure monitoring documents. This increased the risk that staff may not know how often people were experiencing seizures and check they were getting the right support when they did.

●For four people with epilepsy, we found inconsistent and conflicting information in their epilepsy care plans, risk assessments and protocols for administering medicines while they were experiencing a seizure. This increased the risk of people receiving inconsistent or incorrect support that may not meet their needs safely.

●For example, there were inconsistencies and conflicting information regarding: the types of seizures people had and how to recognise them, triggers that increase the risk of seizures occurring, which rescue medicines and oxygen people needed to have during and after a seizure, and how much and when these should be given.

●For these people, their epilepsy care plans and risk assessments lacked identified actions about how to support them during and after a seizure in specific situations, such as when having hydrotherapy. This increased the risk that staff may not know or be able to support people safely to avoid serious harm caused by frequent or long seizures.

●One person's medication administration record, medicine protocols and epilepsy care plans contained different information about the actions staff should take if they experienced frequent or long seizures. This included inconsistencies about which rescue medicines and oxygen they should receive to help manage their seizures safely, who was responsible for administering their medicines and what steps staff should take to escalate concerns for further medical assistance if the person's seizures did not stop. The person's epilepsy seizure management plan directed staff to administer medicines using equipment which not all staff had been trained to use and which was not available at the service.

●There had been an incident on 10 February 2020 where the person had experienced frequent seizures that did not stop. During the incident there had been confusion amongst staff, and medical professionals contacted for advice, about the correct action to take to support the person. This had resulted in an avoidable delay in the person receiving further emergency medicines and medical assistance and placed them at serious risk of harm.

●We requested urgent assurances from the provider about actions they would take to ensure that people's epilepsy care plans and medicine protocols contained clear and concise information and that all staff were aware about the actions to take to support people safely manage their seizures on 13 February 2020. Between 14 and 18 February 2020 we were provided with updated care plans and protocols and confirmation staff knew what action to take.

●However, we received information that a further safeguarding incident had occurred on 18 and 19 February 2020 where there had been confusion amongst staff and medical professionals about the correct action to take to support a person during a prolonged seizure. This was the same person who was involved in the incident on 10 and 11 February 2020. This had again resulted in an avoidable delay in the person receiving further emergency medicines and medical assistance.

●In response to this incident, we visited the service on 21 February 2020 to further evaluate the concerns about epilepsy management since our last site visit the previous week.

●We found not all the updated care guidance that the provider had sent the CQC on 14 February 2020 was in place for staff to refer to. Some updated information had been added but there remained older guidance in use as well, which created a risk of confusion amongst staff about what to do in the event of people having a seizure. There remained conflicting information about what medicines to administer to one person and when and what actions should be taken when their oxygen saturation was at certain levels.

●We spoke with nurses and support staff who acknowledged the inconsistencies and conflicting information and told us they did not understand all the directions in people's epilepsy care plans and protocols. These staff told us they were not confident, or were not aware of, the correct actions to take to support people with their epilepsy needs; including supporting people when they had a seizure and when emergency medicines should be administered. One nurse told us they had found this to be the case when supporting the person on 10 and 11 February when attempting to support the person to stop their prolonged seizure.

●Where actions were identified to safely manage known risks associated with people's epilepsy, these were not always being carried out. A further incident had occurred on 16 February where staff had not taken a person's vital health signs as required following their having a seizure. We found for this person and for one other person this had occurred on multiple occasions since the last inspection. The recording of vital signs is essential to staff being able to assess the person's well-being and if any further clinical interventions may be

necessary.

● There was not always guidance or information to help staff understand how to support people to safely manage their constipation needs. People who had been prescribed PRN laxatives to alleviate their constipation did not always have corresponding guidance about how and when to administer these. This increased the risk that staff may not know how to intervene in a timely manner to keep people safe if they became constipated.

●For example, one person had been prescribed an enema and glycerol suppositories, but there was no direction about which of these PRN to use and when to administer them in their constipation care plan, risk assessment or medical care plan. For this person and another person who was also prescribed an enema, there was not a PRN protocol for how and when to give this.

● Two people's elimination and constipation care plans did not contain details regarding people's risk factors and the actions required to keep them as safe as possible. For example, one person had a bowel condition that increased the chances of their experiencing constipation and other bowel issues. Constipation was also a trigger for the person having an epileptic seizure. There was no detail in their care plans or separate risk assessment about how to safely manage their condition or the associated risks of harm. The person had been recently hospitalised due to experiencing constipation symptoms associated with their bowel condition and had experienced a seizure whilst in A&E.

●Where actions had been identified to help keep people safe if they became constipated, we found these were not always taken by staff. A person had experienced constipation over a period during January 2020. During this period, staff did not offer or give medicines or seek medical advice at the correct time, as per directions in the person's constipation risk assessment and medicine protocol. This placed the person at risk of harm.

● Risks relating to people's physical and non-physical behaviours that may challenge were not always assessed, monitored or managed safely, increasing the risk of harm to people. The functions behind people's challenging behaviours had not always been assessed. Without assessing the reasons behind an individual's challenging behaviour in depth, it increases the risk that staff will not understand or plan how they should respond to behaviours, based on the known function behind them.

●People's behaviour support plans did not always contain adequate guidance about how to support them to prevent their behaviours that may challenge from occurring or escalating. Without guidance to promote preventative and positive interventions from staff to help support people when they display behaviours that may challenge, it increases the risk staff may resort to using reactive and restrictive practices. It also increases the risk that people will experience a poor quality of life and fail to learn new skills to replace the challenging behaviour.

●There had been many recent incidents where people had displayed behaviours that challenged themselves and others, including physically attacking staff and other people at the service.

●One person whose known behaviours could harm themselves or others had no assessment and minimal detail in their care plans about how to minimise this risk. There had been three recent instances of the person hurting themselves or experiencing unexplained bruising. Staff told us they held the person's arms down to stop them hurting themselves and other people, and we observed this happening during the inspection. These interventions had not been risk assessed and there was no clear procedure for staff to

follow. This left the person at risk of coming to harm and being supported in an unsafe and restrictive way.

●One person who was known to display physically challenging behaviour towards staff and other people had a care plan that advised if the person displayed aggression whilst being supported with personal care, staff should leave them in their shower chair until they calmed down. This action had not been risk assessed and there was no guidance about how long to leave the person on their own for and how this should be monitored, to help make sure this was being done safely. This left the person at risk of coming to harm and being supported in an unsafe and restrictive way.

●Where people's behaviour care plans identified actions for staff to take to reduce the risk of their becoming challenging, staff were not always following or aware of these. One person's care plan identified they could become verbally and physically aggressive towards others. They had been allocated eight hours of one to one support each day to help manage this risk, but there had been a recent incident where they had not been supported one to one and had shouted at and attacked another person. It was identified by the manager that having the 1:1 support as directed could have prevented this from happening.

● Staff told us one person was experiencing frequent instances of challenging behaviour. The person's behavioural support plan had not been reviewed since it was written in August 2019. Staff we spoke with, including the clinical lead, were not aware of directions in the person's behaviour plan about when and how to record a behaviour monitoring chart. When staff had completed monitoring charts, they were not sure how the information was reviewed and used to inform the person's support. This increased the risk that staff may not know how often the person was becoming challenging, may not check they were getting the right support, or look at how they could prevent this happening again.

Using Medicines Safely

●Staff had not always ensured that people had received their prescribed emergency PRN medicines for their epilepsy, constipation and behaviour support needs as intended. People did not always have accurate or consistent PRN protocols or medicine care plans, so staff knew how much medicine they needed and when to administer this. Staff we spoke with told us they were not always confident about when to administer people's epilepsy and behaviour support PRN medicines.

● Systems to ensure medicines and equipment were kept clean and stored hygienically were not always operating effectively. We inspected the medicine store room and one person's inhaler for their prescribed medicine was stored in an unclean container and had not been regularly cleaned, despite frequent use and was visibly dirty. This increased the risk of the person experiencing infections.

Learning lessons when things go wrong

● Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again. During this inspection, we identified issues relating to safety incidents that had either not been reported or had not been acted on in relation to people's epilepsy, constipation and behaviours that may challenge.

●For example, an external clinical commissioning review had highlighted the high risk of harm if inconsistencies in a person's seizure management and medicine protocol directions were not clarified. This recommendation had not been acted on and there had been two instances where staff had not known how

to support people safely during their seizures, leading to a delay in their receiving medical treatment.

●Risks associated with epilepsy, constipation and behaviours that may challenge were found at inspections April 2018, February and March 2019 and August 2019. We also found concerns regarding safe management of medicines and failing to learn and make improvements when things had gone wrong at all these inspections. At this inspection, we had found the same risks and safety concerns were continuing.

●Following our inspection on 29 August 2019, we asked the provider for immediate assurances about how they would address the inadequate risk management and unsafe support for people with constipation and epilepsy. The provider sent us information on detailing urgent and on-going actions they would take in response to these concerns. However, the provider had failed to act upon these known areas of concern to improve safety for people.

●The themes of risks and concerns found at this inspection relating to epilepsy, behaviours that may challenge and constipation have been highlighted in inspection reports about many of the provider's other services. This had not led the provider acting to prevent similar risks to people at Horncastle Care Centre being reduced.

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following our visit on 21 February 2020, due to our serious concerns about the safety of people's epilepsy support we wrote to the provider straight away to tell them what action we were proposing to take should the serious concerns not be addressed immediately.

●The provider was invited to, and did put forward, a response within 24 working hours setting out how they had, or how they intended to address the concerns immediately. The provider also informed us of their decision to close the service as soon as it could be arranged for people to find new homes.

●Following receipt of these assurances we are reviewing further information on the progress of these actions on an on-going basis until the service closes.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes protected people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

●Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. One staff member we spoke with was not aware of who to contact outside of the service about possible abuse concerns.

●There had been instances of physically challenging behaviour by people towards other people using the service; unexplained bruising; people not receiving emergency medicines as required, and people experiencing extended periods of constipation. For one-person, appropriate medical intervention had not taken place during and post seizure leading to a delay in their receiving emergency treatment.

●These incidents had not always been reported internally or externally or acted on as required by staff to help understand and prevent them re-occurring. People's needs had been neglected and they were placed at increased risk of future abuse.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked people if they felt safe from abuse and we were told they had no concerns. There was information about how people using the service could raise safeguarding concerns on communal noticeboards.

●Since the last inspection, staff had been supported to complete or update safeguarding training. There had also been a recent group safeguarding supervision take place for the entire team to help improve their safeguarding knowledge. Staff we spoke with could explain how to recognise, report and act to help prevent abuse occurring.

●The manager and nominated individual explained how they were in the process of making changes to information sharing and incident reporting to ensure that any concerns were acted on. There were plans for more extensive further internal support available to help monitor and review safeguarding incidents. A recent incident of alleged physical abuse of a person by staff had been reported externally to the Police and local safeguarding team and acted on appropriately by staff and management to reduce the risks to people and staff involved.

Staffing and recruitment

●Due to staffing vacancies, the provider employed a mix of agency and permanent staff to meet people's needs. We have raised concerns about the deployment, skills and competencies of agency and permanent staff in other sections of this report.

● All staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Permanent staff submitted applications, references and passed a competency-based interview prior to being offered a position.

● All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Preventing and controlling infection

● The provider employed cleaning staff who carried out daily cleaning of communal areas and people's

rooms in the service. Plastic gloves and aprons were available and staff used these when supporting people with their personal care. There were separate catering staff and both they and support workers received food hygiene training to help ensure food was handled and prepared safely.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection we found the provider had failed to deploy staff who had received appropriate support and training and make sure they were competent to carry out their duties. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

●Permanent staff had not been receiving regular supervisions since November 2019. Most permanent RGN and HCA had not either received epilepsy training with competencies, or this training required updating. Behaviour support training was yet to be delivered for most permanent staff. This increased the risk of ineffective or unsafe practice occurring.

● There continued to be high use of agency staff at the service, but agency staff had not always received supervision, training and support to make sure they the right skills, knowledge or experience to deliver effective care to people. Failure to ensure agency staff had the appropriate knowledge and competencies in key areas of people's care had been highlighted at previous inspections but had not improved.

●Agency registered nurses (RGNs) and healthcare assistants (HCA) had not been trained in subjects relevant to people living at the service. Agency RGNs had not received any clinical competency assessments or further training and support. This included subjects related to key areas of people's support needs such as epilepsy, health monitoring tools and behaviours that may challenge.

●We have reported in other sections of this report specific examples we found repeated instances where permanent and agency staff had lacked knowledge and confidence to support people effectively and safely, in relation to their epilepsy, constipation and behaviour needs.

●Both permanent senior HCAs and agency RGNs raised concerns with us during the inspection about the deployment of only one RGN on each shift. All 10 people living at the service and the three people receiving regular respite care had a high level of clinical needs and were primarily reliant solely on this one RGN to support these needs. This increased the risk of a delay in staff being able to provide effective support for

people, including in an emergency. The service consisted of two separate bungalows on the same site. In the event of people needing clinical support, the RGN had to physically leave the bungalow and walk to the other one, further increasing this risk.

●The manager was neither a registered nurse nor completed relevant clinical training in order to effectively guide and monitor the practice of clinical staff such as registered nurses. There had been a clinical lead position employed at the service who was an RGN, but they had recently left, and the position was not being re-recruited to. The organisation's head of clinical services had been based at the service but was not supervising RGNs or overseeing their clinical practice. Senior staff and trainee RGNs were trained or in the process of being trained to provide clinical backup for the RGN to administer medicines.

●An agency nurse told us they did not feel this arrangement was safe or effective. They told us the measure to train HCAs and having trainee RGNS did not reduce their actual workload as they could not carry out many clinical tasks or make many clinical decisions without support.

●The RGN gave us a recent example of when there had been a recent incident of a person experiencing a prolonged seizure whilst there had also been two other people requiring clinical support due to illness at the same time. The RGN had not been supported by other clinically trained staff and this had resulted in a delay in providing the support all three people needed, including escalating concerns for emergency medical advice when this had been necessary for the person having a seizure. The RGN had found this situation very stressful and had been unable to fully concentrate on any one situation, which they felt had contributed to the delay.

●The failure to deploy staff who had received appropriate support, training and personal development and evidence that the service had assured themselves of their competence to carry out the duties they are employed to perform is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We raised our concerns with the provider about staffing during and after the inspection. We received assurances clinical competencies, and any necessary further training, would be delivered to agency and permanent RGNs and HCAs. The provider moved a permanent nurse from another of their services to provide day to day clinical leadership at the service until the point of closure. The provider also arranged for an RGN from their internal quality team to provide additional clinical support for staff and the manager remotely.

Supporting people to live healthier lives, access healthcare services and support, Staff working with other agencies to provide consistent, effective, timely care

● At the last inspection, the provider had not ensured staff had worked effectively with other agencies and ensured the health, safety and welfare of service users. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People's day to day constipation needs were not always met effectively. Staff had not worked effectively with other agencies and ensured people's health, safety and welfare in relation to their epilepsy needs. We have commented more on people's healthcare needs not being met in relation to constipation and epilepsy

in the safe section of this report.

●Nurses and support staff monitored people's well-being daily by talking with people and observing their physical and emotional presentation. Nurses used a standardised system for recording and assessing baseline observations of people's health indicators called National Early Warning Score (NEWS). NEWS was designed to ensure people could be supported to receive or access healthcare support and services quickly.

● Not all permanent or agency nurses had received the necessary training or supervision to know how to use the NEWS systems. We found examples when staff had not acted when people's NEWS scores indicated this was necessary to repeat observations and escalate concerns, and other examples when people's NEWS scores had not been scored correctly. Staff had not always followed directions for one person to take daily NEWS scores, and there was confusion amongst RGNS we spoke with about how often this should be done. This placed people at risk of harm.

●We found multiple instances where nurses had not taken NEWS scores post-seizure for two people as directed. This had placed the people at risk as staff would not have known if they required further medical support, such as administering oxygen.

●For some people, there was a lack of information in their care records about the pathway to follow to escalate healthcare concerns, including unplanned admission to a hospital, and the support they needed once they had left the care of the provider. Where information was missing, staff we spoke with could not tell us about the expected pathways and how they would share information. This placed people at risk of harm and of not receiving the treatment they needed in a timely manner.

● The failure to ensure the health, safety and welfare of service users is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection we received some feedback from health and social care professionals about improvements with staff engagement with their agencies when working together, although work was still on-going to be able to evidence effective outcomes for people. One professional said. "There are some signs of progress, but it is slow going".

●People we spoke with told us they did not have any concerns about their day to day healthcare needs. One person told us they had support to visit the doctor and the dentist when they needed to.

Ensuring consent to care and treatment in line with law and guidance

At the last inspection, the provider had not ensured service users consent to care and treatment had been sought in accordance with legislation. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least

restrictive as possible.

●People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's consent to care and treatment had not always been sought in line with the MCA. Where people might lack mental capacity to be able to make certain decisions, this had not always been assessed. For some people, this included a lack of mental capacity assessment regarding decisions about specific healthcare treatment including end of life care, medicines they received and forms of restraint they were subject to. We have commented more on the impact this had on people in the Safe and Responsive sections of the report.

●Where people had authorised DoLS, relevant DoLS conditions were not always clearly identified and staff were not always aware of who had them, or what they were. People's DoLS conditions were not always being met. One person's DoLS was subject to a condition regarding supporting them to ensure arrangements were in place for them to regularly visit their family, but this had not been done.

The provider had failed to ensure service users consent to care and treatment had been sought in accordance with legislation. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLS were currently authorised for most people or in process of being re-applied for. The provider was in the process of delivering further MCA and DoLS training to all staff to help improve their knowledge and skills.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Some people with behaviours that may challenge had not been supported to assess the reasons they may display behaviour that may challenge, in line with best practice guidance. We have reported more on this in the Safe section of the report.

●Some people's social activities, communication and psychological support needs and choices had not been effectively assessed to help achieve effective outcomes. We have reported more on this in the Responsive section of the report.

●Staff had used NEWS guidance and tools to assess and monitor people's vital health signs. However, assessments of people's NEWS scores had not been effectively put into practice and we have reported more on this in the Safe and in this section of this report.

● People had been supported in line with nationally recognised best practice guidance when considering some of their healthcare needs. Staff used 'Waterlow' and MUST tools to assess people's risk of pressure damage and nutritional needs and we found people had achieved successful outcomes in these areas.

●Staff assessed some people's pain relief needs using the 'Wong-Baker faces' tool. This is a pictorial scale that helps people to explain about how much pain they are in, to help staff more effectively identify and

remedy the cause of the pain.

Supporting people to eat and drink enough to maintain a balanced diet

● At the last inspection we found that risks to people with complex needs in relation to their eating and drinking and received their fluids and nutrition via a tube to their stomach (PEG tubes) were not always monitored or managed safely. At this inspection all people with a PEG tube had since moved out.

● People had support to have a balanced diet and the correct nutrition. People had been referred to dieticians and speech and language therapists (SaLT) to provide guidelines to help ensure their nutritional needs were met. People's food was prepared by a chef, who had access to and followed the directions in people's eating and drinking guidelines.

●People had enough to eat and drink. One person told us they could ask for food outside of set meal times whenever they wanted. We saw people had support to have or access regular fluids throughout the day.

●People were involved in developing menus, which changed regularly. People were offered different meal choices daily. The service could cater for any religious or cultural food preferences, if these were requested. People we spoke with were generally complimentary about the food.

Adapting service, design, decoration to meet people's needs

● The premises had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access and electronic door open and closing devices to allow people to move around the premises independently. Equipment such as ceiling track hoists had been installed in individual bathrooms and bedrooms to support people with mobility support needs to transfer from one place to another.

●There were large outside gardens and smaller outside spaces outside of each bedroom that were wheelchair accessible. One person told us they very much liked the outside spaces and they loved going out into the gardens and looking at the views.

●There was a large central communal space and smaller communal areas in both bungalows, where people could eat and spend time taking part in activities or socialising. People could spend time in their rooms if they wanted to be alone and have private visitors. People told us they appreciated that they could also often use the smaller communal spaces if it was busy in the larger areas to spend quiet time with people or on their own.

●There was appropriate signage on doors to toilets and other communal rooms and facilities, to help people find their way around the building. Communal areas were decorated with pictures created by, and photographs of, people. People had personalised their bedrooms with their own furniture and decorations.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

At the last inspection, staff did not always treat people with respect and dignity when they were supporting them. People's support documents and care plans contained disrespectful language towards people's health conditions and disabilities. Staff did not always seek accessible ways to communicate with people.

There was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvements remained necessary, but the breach of Regulation 10 had been met.

●At the last inspection, people's support documents and care plans contained disrespectful language towards people's health conditions and disabilities. We found improvements had been made in some care plans we looked at, but one person's behaviour care plan still contained disrespectful language about their mental health needs.

●At the last inspection we saw staff did not always treat people with dignity or respect when supporting them. At this inspection, we saw one example where a staff member moved a person without their permission whilst holding a conversation about the person over their head with a visiting professional. On another occasion we saw a staff member put their finger to their lips to two different people on separate occasions to tell them to be quiet.

●Other staff we spoke with told us they understood the importance of treating people with dignity and allowing people options so they could make their own decisions. We saw several instances where staff allowed people time to express themselves and respected their choices.

●For example, one person asked a staff member to help them move their feet as they were unable to do this themselves. The staff member got down low and asked the person which way they wanted to move, adjusted their feet gently and asked if that was ok. The person mentioned their trouser leg needed straightening and the staff member did this and checked if the person was happy.

● At the last inspection staff did not always use Makaton when supporting with people who communicated using this. Makaton is a language programme using signs and symbols to help people to communicate. We found that this continued to be the case for one person, which impacted on the person's ability to communicate and be understood consistently by staff.

●We observed other instances where staff did communicate with people in accessible way. For example, staff spoke to people clearly at their eye-level and phrased questions and sentences in ways people understood. We observed several positive interactions where staff supported people using appropriate touch and pleasant tones of voice to engage and interact with people.

●People we spoke with told us they got on well with staff. Staff talked to people in a friendly manner and people appeared relaxed in staff company. We saw several times when staff and people were sharing a joke and laughing together and another time when staff joined in singing a person's favourite song with them that was playing.

●People told us that staff acted with compassion and responded to their emotional well-being in a meaningful way. One person said, "I get stressed, but staff will reassure me. I am waiting for a date for hospital. I am frightened, but staff check I am ok".

●One person said to us staff knew and respected their independence to be able to do tasks themselves. Staff told us they had started helping one person learn Makaton and hoped to improve in this area to support other people to also learn new skills. The manager told us they were in the process of arranging and delivering more Makaton and communication training for staff from the provider's quality team.

●Staff told us they understood about making sure they respected people's privacy. One staff said, "You ask to enter a room make sure doors are closed. If staff have to enter people's room they ask permission, making sure they have their dignity." There were data protection and record keeping polices in place to make sure that people's personal information was correctly stored, used and shared.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences, Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● We reviewed five people's care plans and found limited information about their personal history, individual likes and dislikes, interests, and how these informed their support needs and choices. This presented a risk people may not receive personalised support. For example, one person with autism benefitted from having a fixed routine. Their care plan identified this but gave no other information about the routine they wanted and needed. Staff could not describe the person's fixed routine when asked and records did not show they had been supported to plan and implement one.

●For these five people, they or relevant people such as relatives or healthcare professionals had not always been involved in either planning and reviewing their care. People had not always been supported to identify on-going individual aspirations and life goals. This presented a risk that staff may not deliver meaningful support to people, are be able to respond if their needs changed.

●We identified at the last inspection that one person required support to maintain a meaningful relationship with their relative. A staff member told us that on-going work was still required and there had been no further action to provide the person with options and alternatives to protect against any future disruption or end to that relationship.

●People's activity records did not show they had always had support to follow their interests or had taken part in social activities they liked to do. We observed people being supported with group and individual activities at the service during the visits on 12 and 13 February 2020. We saw that people and staff did not always engage positively in the activities or with each other and it was not always evident the activities on offer were appropriate or meaningful for people.

●People were not always able to access the wider community, to take part in meaningful activities and avoid social isolation. People's activity records showed people had left the service infrequently. For example, seven people had left the service less than once a week on average for the period 3 January to 14 February 2020. One person had not left the service at all during this period.

●We asked the manager what the reasons for people not going out very often were. They told us, "We need

to know more about what people might like to do and when they might want to go out. People here have been used to just doing activities inside and not going out".

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff had not always identified how to meet the communication needs of people with a disability or sensory loss. One person had a visual impairment but their care plans, including their communication care plan, did not highlight how to take this into account to ensure they were given information in a way they could understand.

●One person had been identified in December 2019 as requiring more support to be involved with choosing activities they liked to do, including using their preferred communication tools to do this. A report had been created to help record this process. Where staff had completed the reports, these had not been reviewed and the reports failed to evidence the person's involvement or that staff had used their preferred methods of communication when supporting them.

●At the last inspection we found people's care plans were not always available in their preferred 'easy-read format'. At this inspection we found that work had begun to create some easy read care plans for one person but was still on-going. Another person who preferred their care plans in this format did not yet have any available. Activity meeting minutes were only available in written format, meaning for some people these were not accessible.

The provider was not ensuring people received person-centred care. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A person we spoke with told us they had regular visitors. A relative we spoke with told us they were always welcome at the service and could come whenever they wanted. We observed several people have visits from family members during the inspection and staff welcomed them with a pleasant attitude.

●The activities co-ordinator was in the process of implementing a more structured personalised activity schedule for people. There had been recent 'activity committee meetings' with people to gain their views on how this should be done. The activities co-ordinator had recently introduced new activity records and planned moving forward to assess and evaluate the activity records to consider if the activities are meaningful and meeting people's needs.

●A person we spoke with told us that staff helped them to understand their care plan by reading it out to them as they had trouble reading letters and words. There were plans to provide a communal pictorial activity board to help communicate more accessibly what activities people had chosen and when these were on offer.

End of life care and support

● At the last inspection, not all people had detailed end of life care plans. A review to re-assess and comprehensively plan all people's end of life care needs was taking place. At this inspection we were told that this work had yet to be completed for most of the people living at the service.

● One person had been supported to create an 'Advance care plan' detailing how they should receive end of life care to avoid the need to be treated in a hospital should they become seriously unwell and their condition worsen.

●The provider had not ensured that the person and other people involved in the planning, managing and making of decisions in their end of life care had done so in accordance with MCA legislation. This meant it was not evident that the advance care plan decisions were in accordance with the person's best interests. We have commented on this breach of regulations in the Effective section of the report.

●The person's advance care plan detailed the expected pathway to access healthcare services as well as the necessary medical equipment and resources staff should provide at the service. However, not all equipment and medicines suggested in the plan were available at the service. Details regarding the support from other healthcare services at the end of the person's life had not been assessed or reviewed adequately to ensure they were achievable.

●There had been two recent incidents where the person had been seriously unwell, and their health had deteriorated considerably. The provider's staff were not able to provide all the suggested medicines at the service and both the provider's staff and the other healthcare services involved did not follow the advance care plan pathway. This had resulted in a delay in the person receiving the correct medical assistance on both occasions. This meant the person had not been able to be as comfortable and as dignified as possible before they passed away. We have commented more on the failure to assess and review the risks this placed the person at in the Safe section of the report.

Improving care quality in response to complaints or concerns

●The provider had a complaints policy that was available for people in an accessible form. One person we spoke with told us they were confident to make a complaint to anyone within the provider's organisation. They said, "I would go to the manager or email further up the line, so above the manager". Any complaints received were logged and actions recorded to show how they had been addressed.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

● At the last inspection, the provider was failing to assess, monitor and improve the quality and safety of the services provided and maintain an accurate and cotemporaneous record in respect of each service user. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

●People remained at risk of receiving unsafe, poor quality or inadequate support. Although at this inspection we found that a breach of regulation 10 had been met, the provider continued to be in breach of six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included regulations 9, 11, 12, 13, 17 and 18 in relation to: person centred care, safe care and treatment, consent, safeguarding people from abuse, good governance and staffing. We have also identified a new breach of CQC (Registration) Regulations 2009 regulation 18.

●The risks and concerns found at this inspection have been highlighted in inspection reports about many of the provider's other services. This information had not led to similar risks to people at Horncastle Care Centre being reduced.

●The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Horncastle Care Centre. We had received written assurances following the August 2019 inspection that the provider would be acting to address serious concerns regarding people's epilepsy and constipation risks not being safely managed. These assurances had not been substantive and at this inspection we had found these concerns remained.

●Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. Since the last inspection, internal audits had not been occurring consistently to help identify and monitor risks, issues and areas of improvement to build upon. The deployment of on-site

support from the organisations head of clinical operations had not included responsibilities for clinical oversight or monitoring of RGN practice and had not prevented issues we found during this inspection from occurring.

●Since the last inspection, external audits from the local authority and clinical commissioning group (CCG) had taken place frequently, and this had helped to form most of the recent assessments the quality and safety of service delivery and what needed to be done to improve this. Much of this auditing had been in response to safeguarding issues that the provider had not always been aware of and had not been taking appropriate steps before alerts had been raised externally.

● Service management and the provider's wider governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. Where audits had been completed internally and externally and actions were identified to address issues, there was a process for recording these on a centrally accessible electronic improvement plan (SIP) as well by when they should be addressed.

●The manager was not always updating the SIP electronically. Although the Nominated individual was having weekly calls with the manager, central oversight of the plan was effectively limited to verbal updates. The manager and nominated individual were unable to provide an accurate current plan to help evaluate governance systems during the inspection.

●We were sent an updated electronic copy of the SIP following the inspection and saw that many high-risk issues and the associated actions were incomplete and had significantly overrun their timeframes for safe completion. This included actions in relation to people's PRN medicines – including constipation and epilepsy medicines and oxygen, MCA and best interest decisions, behaviours, activities and communication support that had been outstanding dating back to August 2019.

●During this inspection, we found the provider had not assessed, monitored and reduced risks relating to the health and safety of service users. Failure to manage epilepsy and constipation risks had resulted in people not receiving medical treatment or medicines when they needed them. Failure to manage on-going epilepsy, medicines and behaviours that may challenge risks had exposed people to a consistently high risk of harm.

● People's care plans and risk assessments regarding MCA, advance care and end of life, epilepsy, medicines, behaviours that may challenge, activities, and social support needs were not always accurate, complete or up to date.

●The provider had not ensured that staff at all levels understood their responsibilities and managed staff accountability effectively. Staff had not always met people's support needs or reported and acted in response to quality and safety issues. Staff continued to not always have the right, skills, knowledge or experience to manage risks and deliver safe, caring, responsive or effective care.

Working in partnership with others, How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●Since the last inspection, communication between the provider and partnership agencies following safety incidents regarding the cause of the incidents themselves and the progress and outcomes of actions to address them has been poor.

●The local authority and CCG provided feedback there had been a recent improvement in the provider's willingness to engage with their teams and share information more openly to help address safeguarding and clinical issues. However, there remained concerns about the length of time and resource it has taken to get to this point. The impact of this has been the provider has still not been able to embed all necessary changes needed to improve the quality and safety of people's care.

●CQC have raised concerns with the provider between August 2019 and February 2020 regarding transparency and mis-information on statutory notifications when sharing information in relation to several safety incidents. This included unexpected deaths, repeat hospital admissions for aspiration pneumonia, safety incidents relation to privacy and dignity, consent and personal care related concerns.

● A provider information return submitted in February 2020 identified 19 safety incidents reportable under duty of candour. When we asked for more information about this during the inspection, we were told this would be sent to us, but no further explanation was received. This meant it was not possible to ascertain if something may or may not have gone wrong as a result of people's care and treatment, or how the provider had responded.

●At this inspection although we found there had been an improvement with the number of statutory notifications submitted, we found the provider had not ensured that CQC statutory notifications were always submitted as legally required. This included failing to notify CQC regarding allegations of abuse of people by other people or incidents relating to medicine errors where people had not received their medicines as intended.

The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. The service had not always worked in partnership effectively with other agencies and was not always open and transparent with service users and other relevant persons. This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The failure to ensure that all statutory notifications of incidents related to services of a regulated activity were submitted is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

●CQC have received on-going assurances from the provider regarding ensuring transparency and openness when sharing information. Following the inspection, the nominated individual shared plans to help support the manager and staff to improve the accuracy and quality of their statutory notifications.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider's vision was that the highest quality care, based on the needs of the individual, was delivered by highly skilled professional teams. Since the last inspection, staff had not always displayed values consistent with the provider's vision of service delivery. Following this inspection, the service has been in breach of multiple Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 over three consecutive inspections between February 2019 and February 2020.

●The manager told us they had not been able to carry out formal performance management supervisions

and arrange necessary training, support and have regular meetings with staff due to their high workload and having to 'fire-fight' priority safety issues. This had impacted on their ability to effectively manage delegated tasks and ensure that the provider's vision was consistently reflected in staff practice.

●Since the last inspection, a permanent manager had been recruited following a period where a peripatetic manager had been in post for a short time. People we spoke with told us they liked the latest manager and had spoken to him about their support. Staff were generally positive about the manager's support. One staff told us how the manager had started to improve the culture and practice at the service by encouraging staff to be more open and honest. They said, "In my opinion, they have helped pull the team together".

●The provider was now producing a monthly internal 'Care Quality Matters' newsletter to help positively identify areas of staff responsibility that needed improving, sign-post support and information available to help staff fulfil their roles and recognise good practice across the organisation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●There were meetings for people who used the service each month to gain their ideas and choices about their activities. People with said the provider had also arranged meetings to explain and update them on service developments when this was necessary, to make sure they were up to date. A relative we spoke with told us the provider had been in regular contact with them about the way forward for the service since the last inspection and had invited their feedback about this.