Leonard Cheshire Disability

Heatherley - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heatherley - Care Home with Nursing Physical Disabilities is a residential care home that provide personal and nursing care for a maximum of 42 people. At the time of our inspection the service was providing care to 39 people and another person was in hospital. People live either in the main building or in one of eight self-contained bungalows located within the grounds. People who live in the bungalows use the facilities in the main building at any time of day or night. People living at Heatherley may have a learning disability, acquired brain injury, stroke, cerebral palsy or multiple sclerosis.

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

There were not sufficient staff deployed at the service which left people at risk. Risks associated with people's care was not always being managed in a safe way including people's nutrition and hydration.

Staff had not received appropriate training and supervision in relation to their role. Advice from health care professionals was not always being following by staff. Staff were not always communicating accurate information about people's care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. People had access to health care professionals to support them with their care. People and relatives told us that staff were kind and caring and we did see examples of this.

Quality assurance was not always effective. Where shortfalls in care had been identified with staff this had not been addressed robustly. The leadership needed to be more effective in ensuring staff were delivering appropriate care. The provider had failed to maintain robust oversight of the service. As a result, the level of care had deteriorated since the last inspection.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting did not maximise people's choice, control and independence. People did not have direct links to the community and choices around meaningful activities were limited.

Right care:
• Care was not person-centred and did not always promote people's dignity, privacy and human rights. People were left alone for extended periods of time in their room and not all staff had an understanding people's preferences around care.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. People were admitted to the service without consideration from the provider about whether it was an appropriate setting for them.

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)
The last rating for this service was Good (published 12 February 2019).

Why we inspected
The inspection was prompted in part due to concerns raised to us from health care professionals about the safe care and treatment for people and the staff levels. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well Led sections of this full report.

As result of the visit the provider has provided us with assurances they will not be admitting people to the service until improvements have been made.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to low staffing levels and lack of training and supervision of staff, safe care was not always being provided to people and people were not being appropriately supported with adequate nutrition and hydration. The provider was not able to demonstrate how the provider was meeting some of the underpinning principles of Right support, Right care, Right culture, and guidance from health care professional not always being followed. The provider was not applying the principles of the Mental Capacity Act and there was a lack of robust provider and management quality assurance at this inspection.

Follow up

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Heatherley - Care Home with Nursing Physical Disabilities

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Our inspection was completed by three inspectors.

Service and service type
Heatherley - Care Home with Nursing Physical Disabilities is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the Provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with six people who used the service about their experience of the care provided and one relative. We also observed care and interaction between people and staff. We spoke with 11 members of staff including the interim manager (manager), the deputy manager, nursing staff, activity staff, catering staff and care staff.

We reviewed a range of records including multiple medication records, safeguarding records, food and hydration records, six care plans for people. We also reviewed the nurse and care staff communication books.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, recruitment files for four members of staff, policies, meeting minutes, surveys, audits and two people's care records.

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● There was a shortage of staff which placed people at risk of harm. Health care professionals fed back to us they had observed people often left on their own in their rooms for long periods of time. This was a particular risk due to people at risk of seizures or choking due to their health conditions. One relative told us, "She's not used to being left on her own but there is a lack of supervision if there's nothing going on." We observed in the morning three people left in their rooms without frequent staff presence. A member of staff told us, "I hate seeing these young people just sat in their rooms and not having time for them." A health care professional told us, "I don't there enough staff to give them the care they need."

● One person told us at times they had to stay in bed due to low staff levels. They told us, "We are left without showers or left in bed." Staff confirmed this telling us they had to prioritise their work and people's safety and at times people may be left in bed.

● People fed back they were on a schedule of baths and showers. One told us, "I would like a shower when I want but I get allocated two a week, last week I only had one. If I had a choice I would love more." Staff told us the schedule was to manage the workload. They said, "We need to start getting people up from seven for breakfast. We have a schedule for baths." They told us they could not always give baths or showers as it dependent on how many staff were on shift as people required two staff to support with this. One member of staff said, "There have been a few occasions when we haven't had enough staff so don't have the quality time for that."

● We reviewed the baths and shower records for four people. One person had not had a bath or shower for over two weeks and there was no record they were refusing this. Another person's care plan stated they liked a shower every day, yet the records showed they had not had a shower for nine days and another person had not had a bath or shower since 16 September 2021.

● Staff fed back there were not sufficient staff on shift each day. One member of staff said, "Sometimes we are short staffed. Pretty often." Other comments included, "It's a struggle", "We're struggling with staff and there's loads of agency. It's really stressful, we're always on the run to do things" and "We are really short staffed. The main problem is staff leaving and we are not replacing enough."

● We reviewed the call bell audits for October 2021 and noted 13 occasions where people had to wait more than 10 minutes for the call bell to be responded to. Four of these occasions people waited more than 15 minutes. Notes on the audit referenced that on five of these days there were less than the required numbers of staff on duty. A staff meeting in September 2021 also raised this concern with the minutes stating, "[Deputy manager] recognised that the staff team are working under pressure with low numbers on some days." This was despite us being told by a senior member of staff that there had only been one occasion where they fallen below their expected levels in September 2021.

● There was mixed response from people about whether there were adequate staff to support them. Comments included, "We are short staffed. Sometimes we are five short as agency haven't turned up",

"They haven't got enough staff" and "We have to wait at times." Another person told us, "I don't have to wait for staff. I just call the bell."

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We have been advised by the Provider that there are ongoing efforts being made to attract and recruit new staff, though it is recognised this is proving difficult and slow given that there is currently a national shortage of staff to work within health and social care
● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people. We saw that nurses' professional registration was in date.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely
● Risks associated with people's care was not always managed in a safe way. Staff were not always supporting people to eat at an appropriate pace. One person who was supported with meals told us, "Some [staff] are too fast."
● Prior to the inspection the local authority told us that one person had recently been admitted to hospital due to aspirational pneumonia which could be caused when food or liquid is breathed into the lungs. We observed one person at risk of this being supported with their meal. The person's care notes states to allow 15 seconds between mouthfuls however the member of staff was not following this and was offering mouthfuls of food more frequently. A health care professional told us of another person that needed support to eat, "He needs encouragement and time and feels like he is being rushed."
● The Malnutrition Universal Screening Tool (MUST) assessment used to determine whether people were at risk of malnutrition or dehydration was not always updated when people had lost weight. For example, according to their weight chart a person lost two kilograms on 29 September 2021. Their MUST had not been updated for a further two weeks. The person's MUST again had not been completed after the person lost a further two kilograms of weight after this.
● People at risk of choking were not always being supported in an appropriate way. Guidance in one person's care plan stated they needed to be encouraged to have their head raised when eating. We observed staff did not ensure this was done and the person was supported to eat when their head was down.
● Equipment required to support people was not always fit for purpose putting people at risk. There were people at the service that required a 'sleep system.' This is prescribed equipment from a physiotherapist to aid sleep positioning. A health care professional told us they visited the service in October 2021 and found a person's equipment was old and worn, there was very little padding on the cushions. The health care professional fed back, "This would cause the (person's) body to be almost on metal." The person had developed a friction mark under their arm due to failing equipment. This had not been reported to the relevant health care professional by staff before the visit but by another health care professional visiting the service.
● We found improvements had not always been made where incidents had occurred. For example, there were people that were at risk of aspiration and one person had been admitted to hospital with aspirational pneumonia. Guidance around this was that people needed to be supported with their meals at a slow pace. However, on the inspection we observed staff offering mouthfuls of food to people at a pace not in line with the guidance in the person's risk assessment.
● There were not appropriate systems in place to ensure people received their prescribed topical medicines.

We reviewed the cream charts for eight people and found all of these had gaps. For one person there were eight days where it was not recorded whether the person had their creams applied. Not all people's body maps were completed to indicate where people needed their creams applied or whether the creams were required on an 'as and when' basis or needed to be applied every day.

The failure to not always manage risks associated with people's care in a safe way and the management of certain medicines were not always robust is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People said they felt safe with staff. One person told us, "I feel safe, of course I do. I could say if I didn't." A relative told us, "That's really where we can relax. I feel she is absolutely safe."
● There were aspects of the management of risk that was undertaken in a safe way. One person told us, "The staff know exactly what they are doing with handling and personal care." People had walking aids and wheelchairs to assist them. There were adequate numbers and selection of hoists to assist staff to support the people requiring transfer that had been regularly serviced.
● Protocols were in place for people that were at risk of seizures including signs to look out for, what clinical care was required and at what stage staff needed to call an ambulance.
● We did see examples of incident reports where appropriate actions had been taken to reduce risk. For example, one person's foot slipped whilst being supported with a standing hoist. As a result, their moving and handling risk assessment had been reviewed. Another person had climbed over their bed rail and had fallen. The person's bed rail had now been removed, their bed lowered, and a crash mat put in place on the floor.
● There were Personal Evacuation Plans (PEEPS) in place for people with details around how they needed to be supported in the event of an emergency. Health and safety checks of the environment were undertaken regularly.
● There were appropriate systems in place to ensure the safe storage of medicines. Aside from topical creams other medicines were recorded on electronic Medicine Administration Records (MAR) with a dated picture of the person, details of allergies, and other appropriate information for example if the person had swallowing difficulties. In the event of a missed medicines, the system would alert staff of this.
● We observed the nurse checked people's blood sugar levels where the person had diabetes. They discussed with the person why the result was slightly higher and asked them what they had eaten in the morning. Nurses had been competency assessed to ensure that they had the skills required to administer medicines.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of neglect. We identified people were being left in bed, left isolated in their rooms and not being provided with baths and showers for long periods of time. This was not recognised by senior leaders of staff as neglect with managers instructing staff to leave people in bed as identified on staff meeting minutes.
● "We saw from the staff communication book on the 9 October 2021 that a relative raised a concern their family member had not had regular baths or showers since they were admitted to the service on 21 September 2021. The care plan stated the person was, 'Used to a daily shower' however over a 29-day period the person only had four baths and three showers
● There were people at the service who were at greater risk of neglect as they were not able to verbally communicate. We saw from staff meeting minutes in September 2021 that "At times recently the decision has had to be made to leave a person in bed due to the shortage of staff." It stated that staff were concerned people who were unable to verbally communicate would be left in bed. There was no evidence in the meeting minutes that the senior in charge responded to staff to say this should not happen. This meant staff

and management may make deliberate decisions to leave those people in bed on the basis people were unable to raise their concern about this.
● Although staff told they understood what constituted abuse and the actions to take if they suspected anything, they and senior leaders were not identifying that lack of care including baths and showers and leaving people in bed was neglectful.

As systems were not in place to ensure that people were protected from the risk of neglect and improper treatment this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. We noted that staff tests were being undertaken for arranged for collection the following day. National guidance states, "PCR tests should be done and collected the same day."

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's

- Prior to people moving into the service steps were not always taken by the provider to ensure they could fully meet their needs. The service was providing support to people with a learning disability and recently admitted six younger adults. The provider had not considered the guidance around Right support, Right care, Right culture which advises social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.
- The manager told us, "I think the plan was that once people had settled, we'd look at what was needed." There was a lack of consideration prior to people moving in whether the environment would be suitable and whether they would be the right mix for people already living at the service who were mostly older. A health care professional told us, "They had not anticipated the time and support the people with a learning disability needed."
- There was limited access to meaningful activities for people with a learning disability which was known to the provider before the people were moved in. We observed a lack of meaningful activities for people with a learning disability including no access to sensory rooms. This was also fed back as a concern by visiting health care professionals. One member of staff told us, "People (recently admitted) are all young, I don't think it's the right environment for them. We didn't know much about them before they came. There isn't enough for them here."
- People had limited access to the community which had a particular impact on the people with a learning disability who had previous strong connections with the community. The service was situated outside of town and people were only able to access town or external activities if this was paid for and arranged with relatives. The manager told us before the inspection they would not be able to fund outside activities for people and this would have to be paid for by the person. One member of staff told us, "My main concern is not the learning disability, the main concern is their age, my concern is how they are going to mix. We are in the middle of nowhere." The manager told us the relatives of people had also raised this as a concern. This was also a concern raised to us by health care professionals before the inspection.

As care and treatment was not always delivered in line with current legislation, standards and guidance this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found the corridors were wide and free from obstructions that allowed people using wheelchairs to access the building easily.

● People's rooms were personalised and there was an abundance of specialist equipment at the service, including chairs, hoists and adapted baths and showers. The notice boards were at a low level so people using a wheelchair could see them.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care;
● Staff were not always following guidance provided by health care professionals in relation to people's care. For example, one visiting physiotherapist told us they visited the service in September 2021 and had asked for a person's mattress to be replaced as it was putting the person at risk. However, when they contacted the service a month later this had not been actioned. They asked the staff at the service to action this immediately due to the risks to the person and we confirmed this had taken place.
● Other guidance provided by health care professionals was not always communicated to staff to ensure consistency of care. One person required specialist equipment which had been ordered by the community physiotherapist. In the interim the physiotherapist had provided verbal and photo guidance of how they needed to support the person when they were in bed. This guidance had not been written up in the person's care plan by staff. Although a substantive member of staff was able to tell us how they supported the person only part of this was obvious from the photo. There was a risk other staff just relying upon the photo would not know how to appropriately support the person.
● Another person had been referred to the Speech and Language Therapist (SaLT) as staff had noticed the person was coughing whilst eating. There was no mention in the person's daily notes they had been coughing whilst eating yet staff told us the person was coughing more frequently. This information would have been useful to provide the SaLT for when they visited to accurately assess the person's needs. A health care professional told us, "I waited for a referral for two weeks and got back the wrong paperwork. It's chaotic here. There is a lack of communication, it's really poor."
● The information about people's health that was shared between staff at the handover was not always accurate or detailed. This meant the most appropriate care may not be provided. For example, we observed a handover where the nurse advised staff one person had a sore on their sacrum. However, a member of staff told the nurse the sore was in the middle of the upper part of the person's back. The nurses responded they did not know this.
● The nurse also told staff about the people who were on antibiotics yet did not explain to them the reasons for this or what they had to do in relation to this. The nurse told staff one person was on a food and fluid chart, yet another nurse told us earlier in the inspection the person was only on a food chart.
● Staff told us communication and teamwork was at times lacking. One member of staff told us, "Carers here will always report things to the nurses but sometimes we might have to report health things more than once before they do something." Another said, "Everyone works separately, carers and nurses. Carers will help each other and can manage things and get them done but we sort it between ourselves."

As people were not always supported with the appropriate health care and guidance was not always being followed this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were aspects to healthcare provided to people that were positive. One relative told us, "Healthcare has been brilliant. They organised the flu jab as soon as [their family member] arrived. The GP is visiting next week for assessment. The dietician came in straight away and got her on the system."
● We saw the GP regularly visited the service and health reviews were requested for people. Where people had diabetes or epilepsy there was evidence the appropriate health care professional was involved in their care.

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

● People at risk of malnutrition were not always being supported in an appropriate way. One person had lost eight kilograms in weight since July 2021. Their initial weight loss had been identified by staff on 8 September 2021 however it was a further three weeks before the person was weighed again. The person continued to lose weight and was not placed on weekly weight monitoring until the week of our inspection.

● The person frequently refused meals they were offered, and appropriate steps had not been taken to support the person with foods they preferred. This was also fed back by a member of staff to a health care professional who had recently visited the service. The health care professional told us that a member of staff had approached them and said, "The kitchen is often not providing [person] with the food he asks for and he feels that this is one of the reasons he refuses to eat."

● According to the nurse's clinical risk meeting in August 2021 there was a requirement for, "Two weekly weights for eight people and report to nurses if there is any weight loss." However, we reviewed the weights charts for people and only monthly weights were being recorded.

● People were at risk of not receiving adequate hydration. We reviewed the records of GP visits for all people living at the service for the month of October 2021. We identified four people had suffered with a urinal tract infection (UTI) which can be triggered when people have not been sufficiently hydrated. This was despite the deputy manager telling us at the point of inspection there had only been one instance of a UTI over a three-month period. Of the people that had UTIs there was no formal monitoring taking place of fluid intake.

● Where people's fluid was being recorded there was insufficient detail on the record of the target fluid the person needed to have. Neither was there any totals undertaken of their fluid intake each day. For one person their fluid record was inconsistently completed and often there was no record of whether the person had been offered drinks through the day. Over a two-week period, the majority of days it was recorded the person was only offered between 200-400 millilitres of drink. This concern around the inconsistent completion of fluid charts was also raised at the service clinical meeting with nurses in August 2021 and no effective action was taken.

● People were not always offered varied choices of meals. The chef told us they offered one meat and one vegetarian dish. There were people that were vegetarians, and this limited their choice to one of the options. The chef told us all other people always chose the meat option which indicated the majority of people preferred meat. However no additional meat options were provided. The chef did have a list of people's nutritional requirements however there was no list of people's preferences.

● There were varied responses from people about the food. Comments included, "Its lovely", "The mince is grisly, bony, lumpy. They cook in the morning and keep it warm" and "I know what I like and don't like, and the staff know too." People told us there were no variety to the desserts provided. One person said, "We don't get nice puddings. It's usually fruit and yoghurt." This was also raised in a meeting with staff in July 2021. The minutes stated, "The residents have a lot of yoghurts. It is not always ok……there should be more options for desserts."

● One person told us snacks were not available between meals and they would have to purchase snacks from the tuck shop at the service. They also told us they were on a restricted diet which they said the tuck shop did not cater for. We talked about this with the manager who told us biscuits were usually on the trolley however this would not have been suitable for people on a restricted or modified diet.

As there was a risk that people were not supported to eat and drink enough to maintain a balanced diet this is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Where people had capacity to make decisions this was not always being considered by staff who were at times making decisions for them. For example, one person had capacity to make decisions. They preferred specific foods however they were being refused as staff felt this was unsafe for them. A member of staff said, "Sometimes he chooses risky food. Sometimes he can't have it. He wants it." The manager told us they were not aware of this and risks should have been discussed with the person so they could make their own decision.
● Where decisions were being made for people there was not always evidence their capacity had been assessed. For example, one person had a bed rail and a lap belt on their wheelchair. There was no assessment of the person's capacity to agree to either of these or evidence of the discussion to determine that this was in the person's best interest or whether less restrictive measures had been considered.
● Other care plans detailed where people had restrictions in place however there was only one capacity assessment in place for all of these restrictions. There were best interest meetings recorded but not specific to each decision made. They usually just stated it was the least restrictive and in the best interest with no additional information. This was despite the service policy stating in these circumstances' , "There should then be one or more mental capacity assessments and best interests decision forms completed to evidence this."
● Staff had received training in the past around MCA and DoLS however there was a lack of understanding of the principals involved.
● DoLS applications had been submitted to the Local Authority and reviewed where necessary.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
● People were not always supported by staff who understand their needs or had training around their specific needs. There were people at the service that had a learning disability. No staff at the service had received training about supporting people with learning disabilities with one member of staff saying, "It's definitely had an impact, having people here with a learning disability. The staff aren't used to it. They need specific training." Another told us, "I don't remember [doing] any learning disability training."
● Other training was provided to staff which staff were positive about. Comments included, "We are always provided with training and refreshers" and "They offer training without us having to beg for it." However, this was not always effective in ensuring staff understood this training based on the concerns we identified at the inspection.
● Staff did not always have an appropriate induction around the needs of people. There was a high number of agency staff working at the service who were allocated to work with a permanent member of staff. However agency staff we spoke with had little knowledge of people's health diagnosis or backgrounds. One member of staff told us when asked why a person they were supporting was at the service, "Well, it's all in the care plan." They confirmed they had not read the person's care plan.

● Another member of staff told us, "I learn about the residents when I follow staff and they show me. I haven't read care plans. Think it would have been better to read them." This member of staff was unable to tell us information about the people they were supporting that day other than their bed routine. They told us "I don't know why he is like that" and in relation to another person, "I don't know much about him."
● Staff told us they received supervisions with their manager that included one to one meetings and observation of their practices. However, the observational supervisions were not always effective in identifying shortfalls. We identified poor practice including supporting people at mealtimes, poor oversight from the nurses of nutrition and hydration and lack of choices of meals for people.

As the provider had failed to ensure that staff received appropriate training and supervision this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Good. At this inspection this key question has deteriorated to Inadequate. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- There was no registered manager and the service was being supported part time by an interim manager from another of the providers services. A new manager had been recruited and was due to start at the service in January 2022. People told us communication around this management change could have been improved. One told us they had not been told the registered manager had left, "When staff leave, you don't know. I only find out because my [relative] finds out and tells me." Another told us they had heard rumours about the recruitment of a new manager but had not heard any more.
- Staff told us leadership at the service needed to improve. One told us, "It can be stressful here. There's been a lot of changes and different needs, lots of different managers. I personally don't feel able to approach management."
- Statutory guidance was not always followed in relation to people's care. We found the provider was not meeting the Right support, Right care, Right culture guidance in relation to the support provided to people with a learning disability. The manager told us they and the provider believed this only applied to people living at the service if a learning disability was their 'primary need.' This demonstrated a lack of understanding of this guidance.
- The clinical oversight and audit of people's care was not robust. One nurse told us they had clinical governance meetings. We asked whether they discussed the frequency of UTIs with people and they said they did not and that only one person had a UTI over the last three months. We confirmed from staff communication records this was not the case. There was no day to day management oversight of people's food and fluid records. We reviewed three months of clinical meetings with the nurses where it was raised the food and fluid recording needed to be improved however, we continued to find this concern at the inspection.
- The records relating to people's care were not always accurate or completed appropriately. Hospital passports we reviewed were not updated with people's current needs. For example, one person's hospital passport stated they required to be checked every 30 minutes due to the risk of seizures however a member of staff told us this should have stated every 15 minutes. We saw from the person's room records they were checked every 15 minutes.
- Daily care notes were task-focused and just recorded the care provided. The notes lacked person centred information such as how they presented throughout the day, what activities the person participated in and what conversation topics were spoken about. This information can help provide responsive and personalised care to a person.

● Care was not always person centred and staff's expectation of high-quality care was at times limited. For example, one member of staff told us people received good quality care. When asked to give examples of this they told us, "They have enough continence pads and bed rest in the afternoon."
● The provider had not considered the impact the recent admittance of people to the service had on people already living at the service due to the insufficient increase in staff levels. Comments from people included, "I have started to hate it here. The carers don't listen to what we say", "When I talk no one listens. Makes me feel I don't want to be here. The place has gone downhill" and, "We used to go out a lot but it's depressing not being able to go out."
● The audits undertaken by the provider were not effective in identifying shortfalls. The service improvement plan worked in line with the five key questions and rated accordingly. There were multiple areas identified requiring improvement which had been updated with the concerns raised during our inspection. The provider had not taken sufficient steps to address the shortfalls they identified before our inspection.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Although people had the opportunity to attend residents' meetings these were not used as an opportunity to make improvements. One person told us, "We have residents' meetings, but they don't listen." Another person said, "They don't listen. We mentioned moving the chairs in the dining room when we have meetings [to make space for wheelchairs]." They told us this did not happen.
● People were asked for feedback on the food by staff and asked to contribute to the menu however no changes were made as a result. The chef told us, "People may request things sometimes or we might try things on a few residents to gain their views. I'm happy for them to suggest things." Despite this comment they were unable to give us examples of how this had been tried. This was except for one person who had requested salmon. However, the chef told this could only be offered occasionally as it was expensive. They said, "When I did salmon a while ago everyone loved it so it's a shame."
● We saw meetings and 'Staff listening days' took place where staff where invited to raise their views. However, we saw from the minutes at each staff meeting they were raising the same concerns around staff levels that they did not feel was being addressed. One member of staff told us, "I haven't been to one (meeting) for a long time. We report the same issues, but nothing happens so there's no point in going." Another told us, "There have been so many complaints from staff so management must know but they don't acknowledge it."
● The provider held a 'Resident listening day' in July 2021 for people to feedback individually about all aspects of care at the service. There were some positive feedback raised around people feeling safe and staff being caring. However, there was negative feedback around limited activities, feeling rushed with care by staff and people not always feeling involved in the running of the home including menu choices and lack of communication. There was no action plan from this listening day to determine what steps had been taken to address these areas.

As the provider had failed to ensure systems or processes were established and operated effectively to ensure quality care this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives however felt involved and communicated with on matters around their family members care. One told us, "The area manager wanted to be involved in meeting [relating to their loved one] and the manager has updated him. They have discussed having a separate unit made for people with a learning disability."
● There were positive comments from staff about the leadership at the service. One member of staff told us,

"I feel supported by [managers]. If I have a problem, I can go to them. I will vent things." Other comments included, "[Deputy manager] is very supportive" and "I do feel supported by [management], 100 percent supported."

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

● The provider understood their responsibility to inform people and their families when things had gone wrong. The policy stated, "We will meet the requirement of the Duty of Candour in health and social care and ensure that we are open fair and transparent with people who use our services and with people who act on their behalf."

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately and the environment had not been set up to ensure it met people's needs.

The enforcement action we took:

We have varied conditions of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured requirement of MCA and consent to care and treatment was followed.

The enforcement action we took:

We have varied conditions of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured management of risks associated with people's care was undertaken in a safe way and the management of medicines was not always robust.

The enforcement action we took:

We have varied conditions of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider had not ensured that people were protected from the risk of neglect.

The enforcement action we took:

We have varied conditions of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider had not ensured that people were supported with their nutrition and hydration.

The enforcement action we took:

We have varied conditions of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured systems or processes were established and operated effectively to ensure quality care.

The enforcement action we took:

We have varied conditions of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had not ensured there were appropriate numbers of trained and supervised staff at the service to support people in a safe way.

The enforcement action we took:

We have varied conditions of the providers registration.