Parkcare Homes (No.2) Limited

Bedborough House

Inspection report

Redlands
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Date of inspection visit:
30 July 2019
31 July 2019
06 August 2019

Date of publication:
04 May 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 30 and 31 July and 6 August 2019.

About the service: Bedborough House is a residential care home and was providing personal care to six young adults at the time of the inspection. The service can support up to eight people with Autism and/or other learning disabilities. The home consists of four en-suite bedrooms and four flats which have en-suite bedrooms and a kitchenette. There is also a communal lounge and kitchen available for people to use.

The service had not been developed and designed in line with Registering the Right Support and other best practice guidance. Registering the Right Support ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service had not received planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found : People were not supported to have maximum choice and control of their lives. Staff had not always supported people in their best interests even though the policies and systems in the service supported this practice. We were not able to converse with all people fully, however two people agreed that staff were caring.

The service didn't apply the full range of 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; limited independence and limited inclusion e.g. People did not receive the activities of their choice and were not involved in the local community.

There were widespread and systemic failings identified during the inspection. The quality and safety monitoring systems used by the provider were not fully effective in ensuring the quality of service provision and mitigate risks to people. This did not ensure people were treated with kindness, dignity and respect.

The provider had failed to make appropriate statutory notifications; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. Safeguarding incidents had not been identified and reported.

The guidance within peoples' risk assessments were not always followed by staff and records used to monitor peoples' health were not always completed. This exposed people to risks of neglect and unsafe or inappropriate care or treatment. People had access to healthcare professionals however we were not assured that staff always identified when referrals were required. People did not always receive their

prescribed medicines as required.

The environment was not maintained effectively, and there was an infection control risk to people using the service.

The provider had a complaints procedure however, not all complaints had been recorded as such or investigated following the provider's complaints procedure.

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

Rating at last inspection: The last rating for this service was Good (August 2018).

Why we inspected : The inspection was prompted in part due to concerns received about medicines, staffing, people's safety, access to activities and record keeping. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all of the sections of this report.

Enforcement: We have identified breaches in relation to medicines, the environment, safeguarding, dignity and respect, infection control, person centred support, staffing, complaints, statutory notifications and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures: 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.

We are mindful of the impact of 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 regularly monitor the service including requesting an action plan to be submitted to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not Safe

Details are in our Safe findings below

Is the service effective?

Inadequate

The service was not Effective

Details are in our Effective findings below

Is the service caring?

Inadequate

The service was not Caring

Details are in our Caring findings below

Is the service responsive?

Inadequate

The service was not Responsive

Details are in our Responsive section below

Is the service well-led?

Inadequate

The service was not Well-Led

Details are in our Well-Led findings below

Bedborough House

Detailed findings

Background to this 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: The inspection team consisted of four inspectors over a period of three days.

Service and service type: Bedborough House 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 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.

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 in April 2018. This included details about incidents the provider must notify us about. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection: We spoke with three people who used the service; they were however unable to relay detailed information to us. We also spoke with six relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, assistant manager, deputy manager, care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and multiple medicines records. We looked at four staff files in relation to recruitment and five staff supervision files and a variety of records relating to the management of the service, including policies and procedures.

After the inspection: We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely; Preventing and controlling infection; Assessing risk; Learning lessons when things go wrong

● During our inspection we identified issues in how medicines were being managed.
When reviewing the records for controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), we saw that the balance did not match the stock levels that were currently kept on site. Some of the medicines which were no longer needed had been removed from the controlled drug cabinet, and were being stored with other medicines which required disposal. This did not comply with the provider's medicine's policy or relevant legislation.

● One person had missed a dose of their medicine as it had not been in stock. The medicine was prescribed to be given every day during the summer, but it had been unavailable for five days prior to the inspection. It had been ordered the day after it ran out but this had not been followed up.

● Another person was receiving medicines to manage their condition. Staff had not followed the directions given by their health care professionals on how to increase the dose, and were now giving a higher dose than had been recommended. The person's care plan had not been updated to reflect changes in the medicines or additional trigger information which was recorded elsewhere in their notes. While reviewing the medicines record and the stock counts we identified two days where the incorrect dose had been given. We were told this would be investigated. The record to show hospital admissions due to the person's condition had not been fully completed.

● Medicines prescribed 'as required' were offered to people but protocols to support staff to administer the medicines consistently were not always sufficiently detailed.

● Training records provided by the registered manager showed that only two staff had medicines training provided by the service. This meant the provider could not be assured that staff administering medicines were qualified to do so.

● The laundry work surface and floor was cluttered not enabling effective cleaning. A red bag used to store soiled linen had been left on top of a sealed unit creating an infection control risk. Lint in the tumble dryer was to be removed following each cycle of drying due to fire hazard. There was a form on the wall for staff to document when they had done this. We looked at the tumble dryer and found lint compacted in the dryer which had not been removed. The form had been completed irregularly with several dates empty.

● Peoples bathrooms were unclean and some of their mattresses worn. One person's mattress had a dip in it and the mat on the floor used for falls risk was frayed and permeable. In this person's en-suite bathroom a wet mop was stored in a bucket. In another person's room the mattress was old and stained. There was no duvet and only a duvet cover. The mattress had been identified as needing replacing in early June 2019, and identified again as the same in late July 2019. No replacement mattress had been ordered. The person's

duvet was ruined but had been left in the corner of the room. A curtain rail had been pulled down and left in the corner too, and doors had been pulled off a cupboard. There was a very strong smell of urine in their en-suite bathroom.

● In the sensory room the furniture was worn, and one chair cover was compromised. These were infection control risks.

● Care plans contained risk assessments for behaviour support and people's physical needs. When risks were identified plans contained guidance for staff on how to reduce the risks to people. However, we found that staff did not always follow the guidance as required. One person was identified as being at risk of their skin breaking down due to them using continence products. The person's care plan included guidance on how to support the person to prevent this, including checking the persons skin every time they received personal care; 'Every four hours at a minimum'. The person was at a higher risk because their care plan identified they, 'Often refuse personal care.' The care plan directed staff to disengage if the person became anxious and to leave the room. Staff were guided to try again later. The person's records showed the checks were not being completed in line with the person's care plan.

● A relative told us about one person's choking risk and said that they were aware that this was not monitored effectively the relative said, "I've seen [person] eating food as [person] walks along which is a no no as [person's] at risk of choking. I have told them [staff] all of this, they know. I tell them that is what we're seeing when we're out on the High Street." We checked this person's care plan and it was clear that they should not be eating whilst walking.

● People were at risk of avoidable harm. There had been multiple incidents in the service in the last 12 months. There were examples of where people had sustained injuries, inflicted injuries on staff, and damaged the service property. The provider had not ensured appropriate measures were in place to reduce these risks following the incidents. Where debriefs from the incident reported staff feeling ill equipped to support people with their challenging behaviour, there was no follow up to ensure staff received additional training or guidance. For example, after one incident a member of staff reported on an incident form that they were 'scared' and did not have the training to support the person involved effectively. There was no additional training provided until it was raised as a concern during the inspection, a few months after the incident. When follow up action was recognised as being required it was not always undertaken quickly. For example, following one serious incident when a staff member was injured, emergency first aid training for staff was reported as being one of the required actions. This did not take place until six months after the incident. We were not assured that the provider learned the lessons when things went wrong and took quick effective action to prevent further risk and incidents.

● The main kitchen posed a potential risk for staff if people became anxious whilst they were in the kitchen. This was because one part of the kitchen was narrow and had no exit, which meant staff could get trapped in that area. The provider had not considered the risks to people created by the design of the kitchen.

● The call alarm system used by staff was not working. It had malfunctioned and could not be reset. Engineers had switched the system off and it was defunct. Staff were using walkie-talkies to call for assistance in the event of an emergency. Walkie-talkies would not however be easy to use in the event of a physical attack. The provider had not considered the risk to staff and people in such an event.

People were not safe because the provider was not managing risks to people effectively. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

● Staffing was not planned effectively; the skill mix and competence of staff, was not factored into the staffing assessment in order to deliver a high-quality person-centred service. The service was also using agency staff who were less familiar with people and had not received relevant training. The level of staffing at the service had allowed the basic levels of one to one [one staff member to one person] support for all

people however, two to one support [two staff members to one person] for people had not been provided as required. Staffing rotas did not account for how people were allocated two to one support hours for activities and access to the community. We found staff initiated this support on an ad hoc basis. Two to one support was mainly funded to enable people's independence and support them to access the community. For some people whose behaviour could be challenging this was essential. For example, one person required two to one support to undertake activities outside of the service to burn off excess energy. When the person was not able to do this their behaviour became challenging and they were prone to damaging the service environment, and disrupting other people. There were other examples of people's behaviour altering in a negative way when they could not access their assessed two to one support activities. Records showed two to one support was not delivered as detailed in people's care plans. The service did not use a dependency assessment tool or have any system in place to ensure staff level deployment was safe and met people's needs. People were supported by staff that were not sufficient in number and skill to meet their needs.

● There was consistent feedback from people, staff, and relatives that there were not enough familiar staff. One person said, "Staff keep leaving, they have been short for ages." Relatives said, "They're supposed to have a core team of four or five people but it's not like that, they have random people. The staffing is terrible" and "It's quite clear [person] was never staffed at agreed levels. It was always a bit vague about who was working with [person]. Clearly inadequate." Staff comments included, "Staffing is awful at the moment… sometimes it can run on two [two staff]… rotas won't reflect there were only two people [staff], always seems to be covered up," and, "I have been here with only two staff."

There were not enough skilled and competent staff to meet peoples' needs safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety monitoring and management

● The service environment was not maintained effectively. There were large trees surrounding the property which had been assessed as being dangerous to people and staff due to falling branches. This had been noted in January 2019 however, despite further numerous governance checks noting the issue no action had been taken to resolve it. In the meantime, access to the garden was restricted to people. The trees also hung over the driveway to the service creating a risk to anyone going to and from the service. The driveway was not lit and had pot holes creating further risk.

● Damage to the property had not been fixed effectively. There were numerous holes in the walls that had been repaired temporarily only to be damaged again. This had been referred to the provider as a concern over a number of months however a permanent solution had not been put into place.

● Records were kept of regular health and safety checks. However, action plans relating to such checks were not always complete. For example, a legionella risk assessment complete in February 2017 made recommendations for high risk actions to be completed within a four-week deadline. They were not completed until April 2018 with one action still outstanding over two years later.

The environment was unsafe, and the provider had not acted to make necessary improvements. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Personal evacuation plans were in place to ensure people were supported to evacuate in the event of a fire

Systems and processes to safeguard people from the risk of abuse

● The service had a policy and procedure regarding the safeguarding of people and guidance was available in the office area for staff to follow. Staff said they had received training on safeguarding people from abuse.

All of the staff we spoke with knew how to report incidents and any concerns. However, people were not always protected from avoidable harm or abuse as staff had not reported incidents that could amount to neglect. Staff had failed to report incidents of neglect when their colleagues did not undertake care and support of people as required. Staff and whistle-blowers recounted occasions when they were aware of neglect by other staff yet failed to report this to the provider or safeguarding authority.

The failure to ensure safeguarding events were identified and reported to the relevant authorities was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

● There was a robust selection procedure for staff. Staff recruitment files showed that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified.

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; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

● People's needs were assessed prior to moving in to the service. The pre-assessment process ensured a comprehensive care plan that detailed guidance for staff on how to meet people's needs. However, the pre-assessment did not consider the personalities and the combined needs of people supported, and their compatibility. There was no introduction period or pre-admission visits to check compatibility. This had resulted in people within the service not getting along, some people withdrawing to their bedrooms and avoiding activities that could enable their independence. For example, there was more than one person living at the service who made a lot of loud noise however, there was also one person whose sensory needs included the need for quiet. This had not been considered prior to these people living together and had resulted in incidents between people, and people withdrawing to their bedrooms. Staff said, "If [name of person] is in the communal areas [name of second person] will not come out of their room, they don't mix well. [Name of person] is outgoing and [name of second person] doesn't like that. Another staff member said, "It's very stressful here at the moment, none of the [people] get on."

● People were supported to use healthcare services; however, there was a lack of assurance that appropriate referrals were raised when there were concerns or that people had support to attend health reviews and planned appointments. For example, one person had been referred to a specialist service however, their appointment was not attended. When we asked the registered manager and the staff why the person had not attended the appointment, no one was able to provide an explanation or record of the reason. A relative described the staff refusing to make an appointment for one person.

●The service had not planned for people to attend regular health reviews such as at the dentist and opticians.

● Actions to manage people's health were not carried out as required. One person needed to be weighed monthly as part of their health-related care plan. We looked at the weight record; it had not been completed for nearly a year. This had not been identified by the service. The registered manager was unable to tell us what the person's weight was and if it had increased or decreased in line with their care plan outcome.

● People had health action plans in place, however they were not always complete. For example, one person's plan was blank in key areas such as their communication requirements.

● People had enough to eat and drink. One person said, "Yes" when we asked them if they were happy with the food provided. However, people's needs in relation to food were not planned and managed

appropriately. One person's care plan stated they were allergic to two foods. One staff member we spoke with was not aware of this and there was no information in the kitchen informing staff of this. This put the person at risk of receiving food that could cause a severe reaction.
● Specialist advice and support had not been sought from a speech and language therapist (SALT) for someone who was at risk of choking. A relative also described seeing a person who was at risk of choking eating whilst walking which was an identified risk to them; staff were accompanying the person and did not act to prevent the risk.

The provider had not ensured people were protected from the risks presented by other people. The provider had failed to ensure people's health needs were monitored effectively and make appropriate health referrals. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Pre– assessments identified people's protected characteristics under the Equalities Act 2010. This included people's needs in relation to their culture, religion and diet. However, the provider did not ensure that training specific for people's needs took place for staff before people came to live at the service.
● Assessments of people's needs were comprehensive, expected outcomes and choices were identified and recorded. However, people's achievement against the outcomes were not documented as many of the activities outside of the service were not taking place as planned. There was no review of this.

Staff support: induction, training, skills and experience
● Staff received training through the provider's essential training programme which included subjects such as safeguarding, fire safety, and infection control. We looked at the staff training matrix and found that staff had received all training which was deemed essential to their role. Specialist training to meet people's specific needs had not been completed by all staff. In particular Asperger's syndrome, Autism Spectrum Disorder, and Learning Disabilities training. Staff had not received training necessary to people they supported. When relatives were asked if they thought staff were well trained they said, "I would say very few are, but on the whole no as they have so many agency staff" and, "There is one [staff member] I would say is excellent with [person]. The rest of them I don't think they know how to deal with person."
● Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The expectation of the provider was that each staff member received a supervision monthly or bi-monthly. We looked at the supervision records of five members of staff; we found that for four staff, supervisions had not been undertaken to the frequency required. The provider had not ensured that staff performance and progress was monitored effectively. This was highly important given the issues within the service.

The provider was unable to demonstrate that staff were provided with opportunities for effective supervision and training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● People had kitchenettes in their flats, the provider confirmed these were to enable people to be supported with their independence. One staff member told us these were not used. They also told us the main kitchen in the home was locked unless a staff member was present. This did not present as a service that was enabling people to be independent.
● The communal lounge of the main service was mostly used by one person. Other people wishing to use the lounge felt unable to use it. There had been no assessment of how the lounge was meeting all people's needs. One person who had previously been sociable, stayed in their bedroom where they also ate their

meals in order to avoid the other person. This situation had not been managed or assessed. The service environment was not meeting people's needs.

The provider had failed to ensure people received support that met their person-centred needs. This was a breach of Regulation 9 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 when this is in their best interests and legally authorised under the MCA.

In care homes, 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.

- Where restrictions had been placed on people's liberty to keep them safe, DoLS authorisation by the local authority had been applied for and granted for some people.
- Staff said that they gained people's consent to receive care.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- The provider had failed to ensure there were sufficiently skilled and proactive staff in place to enable the staff team to provide a caring service. People were often supported by staff unfamiliar with their needs and unable to provide the support required so people could access preferred activities. Relatives said, "Some [staff] very definitely are [caring], we have ones that are really brilliant and compassionate and caring. Some really specifically aren't and are really offensive in the way they talk about [person]. Of course [person's] behaviour will deteriorate if [person's] not looked after." Another relative said, "[Person] is an adult with severe special needs and can't function unless [person] has boundaries. Some of the staff do everything for [person]. They're not supposed to be waiting on [person] hand, foot, and finger, they're meant to be supporting [person]. I do pop in on the off chance and [person's] just wondering around bored. [Person] needs things to do. There are staff that are great with [person] and staff that just sit around, drink coffee, and do nothing.
- In people's care plans there was a lack of keyworker meeting records to demonstrate how people had been involved in expressing their views about their care and making decisions and choices. Relatives said they were not often invited to reviews; one relative described asking for a review which eventually took place months later. Another relative said, "We used to have meetings, but we haven't had one for a long time now, could be about a year."
- A relative told us they had complained because a person had not received their personal care as required. There was no record of this complaint or details of how this was dealt with. One staff member said that on the day of inspection they had been planning to take one person out into the community however, when they arrived at 10am another person had not yet received their breakfast or personal care and was covered in faeces. The staff member said this was a regular occurrence as some staff would leave personal care for other staff to undertake. These incidences failed to protect people's dignity and exposed them to other health related risks.
- Staff said certain people received more attention and support to access the community as they would 'shout all day' until someone took them out. This meant the quieter people received less support; when looking at records we found there were certain people who received much less support to go out. There is further detail in the responsive section of this report.

The failure to involve people and ensure they are treated with kindness, dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received a positive response from some people about staff. One person said, "The staff are really lovely."

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care; 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; Meeting people's communication needs

- Records relating to peoples' care and treatment were not fully completed to protect people from the risks of unsafe care. Personal care records had not been completed to evidence that care had taken place. Night time checks had not been recorded where required. For one person who was at risk of constipation, there were no checks in relation to this, or the amount of fibre in their diet.
- One person had been living at the service for 50 days, staff were required to sign parts of the care plan to show they had read it. 10 out of 19 staff had signed to say they had read the person's care plan. Every care plan we looked at had a similar status in relation to having been 'read' by staff.
- The service had not explored people's preferences and choices in relation to end of life care. Records must include preferences relating to protected characteristics, cultural and spiritual needs.
- Activities were not effectively monitored by the provider for their suitability or for their provision and people were not consistently supported to follow their interests and chosen activities. People had weekly activity planners, but these were not always fully completed each week. For example, one person's care plan identified engaging in specific activities was important to them (adrenaline based). Their care plan stated, '[Name of person] needs regular opportunities to enjoy outdoor activities.' The person was funded for five hours of two to one staff support every day. We reviewed the persons daily records and noted over the period of 30 days in July, they went out on 14 of the days to the local shops, local park, or for a walk. They did not partake in any of their preferred activities. None of the visits were any longer than two hours other than on one day of three hours. On average the visits were of one and a half to one- and three-quarter hours. Another person's care plan identified specific activities outside of the home as being important to them. The person's daily records showed they had 12 out of 30 days in July when they were supported to access the community, despite being funded for four hours every day. A third person's records showed that of the 19 days in June when they were at the service, they went out three times for up to two hours for walks and for dinner (once). This was despite being funded for four hours every day.
- One relative said, "They hadn't taken [person] out and they said [person] was off baseline [change in normal behaviour]. Seems like a good excuse not to take [person] anywhere. [Person] needs stimulation and exercise. We think [person's] being kept in his room absolutely miserable. Promised trips haven't happened." Staff said, "People don't get out every day, especially at the weekends."

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.

● Improvements were needed to ensure people's individual communication needs were assessed, met and recorded in line with the AIS.

● People had communication needs that were identified in their care plans. However, these were not always being met. One person had a specific way of communicating and none of the staff had been trained to support them. The training was being provided on the second day of the inspection some months after the person had come to live at the service. Staff told us this had caused incidents as staff had been unable to support the person effectively. Staff said, "We haven't had training in [specific need]. We've got some of [person's communication needs], if we don't understand [person] smashes up the lounge." The person had a communication dictionary in place, however only two staff members had signed to state they had read this. The persons health action plan stated, things that make me sad, 'Lack of communication'.

The failures to monitor people's health effectively and to ensure people received person centred care and support was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints were not recorded consistently. The provider could not be assured they were aware of the issues affecting people using the service and were unable to act on these complaints to improve the service.

● There were systems in place to respond to complaints however not all complaints had been recorded as such. One person told us they had made a complaint, "A few months ago", they told us they were happy the complaint was resolved. However, there was no record of the complaint in the service complaints file.

● Relatives we spoke with also told us they had made complaints; there were no record of these. One relative said, "We've put in various complaints since [person's] been there. These complaints have been upheld. Relatives had not been made aware of the complaints procedure. Comments from relatives included, "I don't have a copy" and, "No complaints procedure. I do go and talk to somebody though." Without complaints being recorded the provider was unable to use the detail of these complaints to assess for any trends or improvements. This was particularly important as we found that there was significant dissatisfaction amongst people and relatives with regards to some of the issues that had not been recorded as complaints.

The failure to ensure complaints were recorded and investigated satisfactorily was a breach of Regulation 16 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 now 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

- There were widespread and systemic failings identified during the inspection; there were nine breaches of regulations. The shortfalls related to key aspects of the service; safe care and treatment, person centred care, staffing, complaints, statutory notifications and good governance. The provider's quality assurance systems and processes did not ensure they were able to mitigate risks relating to the health, safety and welfare of people. The quality assurance systems were ineffective in directing sufficient resources into the areas that required improvement within a reasonable timescale particularly in relation to the environment and staffing concerns.
- Poor leadership was an issue from the provider level down; the failures to meet standards were compounded by a lack of effective leadership. The provider had failed to provide sufficient support to enable the registered manager to undertake their role effectively and to a good standard. There had been a high turnover of staff and ongoing staff vacancies which had affected the registered manager's ability to manage the service. The registered manager was also registered for two more of the provider's services and was splitting their role between the three services. This had meant the registered manager had less protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. Relatives said, "Standards have dropped like a stone in the last seven, eight months. Everyone we knew and trusted seemed to be leaving or left."
- There was no effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was also a failure to identify recording errors and omissions in the care records and to analyse concerns. We saw records which were incomplete and incorrect. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

Due to poor governance of the service people were placed at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have

been handled. We had not received statutory notifications in relation to safeguarding events and serious injuries; we found evidence of at least three serious injuries that had not been reported.

This failing meant the Commission had been unable to monitor concerns, and consider any follow up action that may have been required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People were not engaged in creating strong links with the local community as their support had been restricted. In addition, there had been incidents in the local community that had led to people from the service being negatively labelled. This had led to some staff not feeling confident in supporting people at this service.

● There was not a positive staff culture. There was a lack of respect for senior staff and a reported culture of staff that worked as required and others that did not, when there was no management presence. Senior staff reported insubordination from their colleagues that remained unchallenged by the registered manager. Staff said, "Team atmosphere is quite bad, people on the team not getting on, [person] picks it up", "Everyone [staff] is tired, a lot of [staff] feel like walking [leaving]," and "Some staff won't work with some people."

● Staff and relatives made varying comments about the management of the service. None of the relatives we spoke to were aware of who the registered manager was. Relatives said "[Since the last registered manager left] you can trace staff leaving, standards in the house dropping", "I'm never too sure of the hierarchy, I go in and sit with [person] and various people have introduced themselves and, "The [provider] needs to get their act together. All I do is moan and pull up on things [complain]." Staff said, "I can talk to the manager" and, "No leadership in the service, I don't feel I can go anywhere with an issue."

Continuous learning and improving care; Working in partnership with others

● Communication about changes in the service was poor. The handover between shifts was ineffective and key information about people was 'lost'. Staff comments included: "The whole place seems like there's no real management or direction which is sad as it could potentially be great and it's a lovely building. Relatives made varying comments around communication, one relative said, "They don't keep in contact with me enough and tell me what's going on." Another relative said they had been contacted frequently lately.

● There was failure to ensure effective supervision and training had taken place as well as staff meetings, this gave little opportunity to provide feedback to staff and to share learning and good practice.

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

● We were not assured that the provider had acted with a duty of candour due to the number of complaints and incidents that had not been recorded or notified effectively.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure statutory notifications were made as required. Regulation 18 (1) (2) of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured effective assessment and delivery of people's needs. The provider had failed to ensure people had access to person-centred activities. This was a breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with kindness, dignity and respect. Regulation 10 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not managing risks to people effectively. The provider had not ensured that staff followed risk assessment guidance appropriately. The provider had failed to ensure people's health needs were monitored effectively and appropriate referrals made to healthcare professionals. Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider had failed to ensure safeguarding events were identified and reported to the relevant authorities. Regulation 13 (1) (2) (3) of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to safely maintain the service environment. This was a breach of Regulation 15 (1) (2) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure complaints were recorded and investigated effectively. Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes did not ensure that they were able to mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service The provider failed to ensure records were completed correctly and accurate. Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of skilled staff to meet people's needs. The provider had not ensured all staff received relevant training to enable them to support people effectively. The provider had failed to ensure staff received

adequate opportunities for supervision.

Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.