Windsor Clinical and Home Care Services Group Ltd

# Apple Hill

**Inspection report**

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

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|---|---|
| Overall rating for this location | Requires Improvement |
| Are services safe? | Requires Improvement |
| Are services effective? | Requires Improvement |
| Are services caring? | Requires Improvement |
| Are services responsive to people's needs? | Requires Improvement |
| Are services well-led? | Requires Improvement |

# Summary of findings

## Overall summary

We rated this location as requires improvement because:

- The service did not always provide safe care. Environments were not always safe or well maintained. Staff did not always fully assess and manage risks to people using the service. The use of restrictive practices was not always managed safely or delivered by staff that had the required training.
- Care plans for people receiving treatment through the mental health rehabilitation pathway were not always recovery-oriented or holistic. Records did not show how the service had assessed or met the entirety of people's needs. Some aspects of the two care pathways were not delivered in line with national guidance and best practice.
- People receiving care under the mental health rehabilitation care pathway had access to a range of specialists required to meet their needs. But there had been a vacancy for an occupational therapist within the service from August 2022 to February 2023 which meant there had been a period where the full range of specialists had not been available.
- Staff did not always understand and fully discharge their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Aspects of care provided did not always uphold the privacy and dignity of people using the service. We observed concerns about some staff interactions, the language used within care records to describe people, and the use of observation peep-holes in some bedroom doors. Arrangements in areas such as facilitating visiting and meeting communication and sensory needs did not consistently promote person-centred care.
- Care plans, risk assessments and behaviour support plans for some people did not evidence people, or those important to them, where appropriate, had been consistently involved in developing and reviewing their plan of care. Some opportunities for engagement were provided, such as regular family meetings and the service shared a regular newsletter.
- Governance processes and systems were not effective and did not always ensure areas of improvement were identified and rectified in good time.

However:

- The service had enough nursing staff. Staff managed medicines safely. Staff completed mandatory training in essential skills including basic life support. Staff felt supported in their roles.
- People who were able to express their views told us they felt safe and we saw some examples where staff had used de-escalation techniques appropriately.
- People using the service had access to good physical healthcare. Where possible staff would seek specialist advice and input.
- Managers ensured permanent staff received supervision and appraisal. The ward staff worked well together and with external agencies involved in care delivery.
- People told us staff were caring and compassionate.

**Detailed findings:**

**Is the service safe?**

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

# Summary of findings

We rated this key question as requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

**Systems and processes to safeguard people from the risk of abuse:**

- Staff had training on how to recognise and report abuse, however we found this was not always applied in practice. For example, one person sustained unexplained injuries which were not consistently reported to the local safeguarding authority.
- We observed a staff member use a form of physical restraint on a person where evidence did not demonstrate it was necessary, lawfully justified, in the person's best interest and in a safe and proportionate way. We reported this to the registered manager who confirmed this was not how staff were expected or trained to support people. They acted immediately to report the incident to the Police and to the Local Safeguarding Authority.
- We received feedback from two people's representatives, who described two prior incidents where it was alleged people had experienced physical abuse. In response to our feedback, the registered manager informed us they had made safeguarding referrals and commenced internal investigations in response to concerns shared.
- One person's records implied the use of interventions which had not been agreed. Staff used phrases such as 'make [person] sit on the sofa' and 'make [person] to lie down on the bed'. This had not been identified as a potential concern which meant the person could have been placed at risk of unnecessary or disproportionate restraint.
- Another person's records stated they were 'escorted' to their bedroom in response to being 'aggressive' without further explanation. Their behaviour plan stated to 'redirect' the person to their bedroom where there are safety concerns but did not provide guidance about how to do this or what staff should do if the person refused. A risk assessment said to ask the person to settle in their bedroom when 'loud and disruptive' to others and that 'behaviour should be settled (minimum of one hour)' before being allowed into the garden. There was no explanation about why this restriction was in place and meant there was an increased risk of the person being secluded in their bedroom without evidence it was necessary, lawfully justified or in the person's best interest.

The service had failed to operate effective systems to identify allegations of abuse, including the risk people may experience unnecessary or disproportionate restraint. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safeguarding and whistleblowing policies were in place. The safeguarding lead for the service had completed level 7 safeguarding training appropriate for their management responsibilities.
- Staff told us they felt comfortable raising concerns with the service management. A staff member advised, "I do always report whatever I see to [the] manager or external safeguarding. [We] have a protocol and policy that we follow, also on notice board [and] also [at] staff meetings [the] manager discuss and remind [staff]."
- Managers conducted enquiries when safeguarding concerns were raised and made changes based on outcomes. For example, a safeguarding enquiry highlighted the importance of staff keeping accurate financial records. This outcome was shared with staff via a 'lessons learnt' process, reminding staff to produce itemised receipts when helping people to make purchases.

**Assessing risk, safety monitoring and management**

- Risk assessments did not always identify risks to people or provide clear and up-to-date guidance about how to reduce risk. Where people's records indicated they were at risk of harm to self or others which may require staff to use restrictive interventions these did not explain what interventions and techniques staff should use. One person's

behaviour plan stated they may grab, push or punch staff without reference to what staff should do in response to this. Another person's risk assessment failed to identify their history of grabbing, squeezing and twisting staff hands and did not refer to a breakaway technique staff recently used. Their behaviour plan instructed staff to 'redirect', 'escort' and stated the person 'may need to be restrained' without further explanation.

- People were not consistently involved in managing risks to themselves and in taking decisions about how to keep safe. One person's risk assessment stated the person's next of kin was involved but did not provide any further details about how they were involved or what contribution they made.
- The use of restrictive practices, including forms of restraint were not always planned, risk assessed or delivered by staff who had received appropriate training. Staff did not receive training in the use of restraint including any type of physical holds, however, we found examples of staff using holds when providing care and treatment. For example, we observed one person's hands and arms were held whilst they were being assisted with care including receiving medicines.
- We identified concerns in relation to fire safety. For example, fire drills did not robustly test whether evacuation procedures were effective to keep people safe. Some fire drills did not record the simulated time taken to evacuate people and times that were recorded far exceeded the expected standard according to the service's fire safety policy and procedure. There was no evidence this was identified or acted upon to make improvements. One person's personal evacuation referred to two evacuation strategies without explanation.
- The provider had not assessed the risk of the layout or number of people using the lounge on one unit, where we observed staff needing to physically move someone's leg to clear a gangway and we observed staff move a sofa where someone was seated to enable wheelchair access. In another example, the service failed to effectively implement specialist's recommendations when a person required padding in their room to reduce the risk of injury. The person continued to experience injuries and had been placed at increased risk.
- Potential ligature anchor points across Walbury and Tedray units had not always been identified or managed. Staff we spoke with did not always know about potential ligature anchor points. The provider had completed a ligature risk assessment for the service that had not identified some ligature anchor points and was not accurate. For example, the toilet in the communal patient bathroom on Walbury ward had not been identified as a ligature anchor point. In areas where the risk of ligature had been categorised as 'high' no specific action plan had been created in response. This meant the provider could not ensure staff were aware of and taking sufficient action to minimise the potential risk of ligatures.
- The service monitored the decibels levels in relation to ongoing construction works. Records for the previous 3 months showed the decibels were 80 and above. We observed the noise levels impacted two people's bedrooms and found staff encouraged people to use other areas of the unit during this time. The construction risk assessment stated control measures included an environmental impact assessment that should have been in place for each person. However, we found the content of people's environmental risk assessments did not include this information.
- Section 17 leave (permission to leave the hospital) risk assessments records were not always being completed in full and lacked detail.

Systems to assess, monitor and mitigate risks to people's health, safety and welfare of people using the service had not been effective. This placed people at increased risk of harm. This was part of a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People who were able to express their views told us they felt safe. Comments from people included, "I always feel safe here" and "[I] do feel safe".

# Summary of findings

- We saw some examples where staff had used de-escalation techniques appropriately to reduce risk to people and keep themselves and others safe. People receiving care through the mental health rehabilitation pathway had not been subject to seclusion, long-term segregation or rapid tranquilisation. Managers said they would not admit people to the service if a person's referral indicated it was likely these aspects of restrictive interventions would be required.
- Relatives provided some positive feedback in relation to risk management. Comments included, "[Person] has his own issues with behaviour. They've [staff] worked wonders with him and kept the other residents safe" and "It's very hard to prevent. They [staff] do everything they can to prevent repeats but [person's] very very strong and…behaves very unpredictably."
- We found other compliance checks were in place such as electrical wiring, portable appliance testing, and service checks on equipment such as hoists.
- We found some risks in relation to people's health needs were well managed. One person lived with unstable diabetes and records showed a detailed protocol was adhered to.
- We also identified some examples where environmental risks had been mitigated. Some people used low profile beds and padded crash mats to reduce the risk of injury and one person used a specialist bed appropriate for their needs.

**Preventing and controlling infection**

- A business continuity plan (BCP) dated January 2023 did not provide information about what would happen if staffing levels were unsafe, such as in the event of an infection outbreak, or make reference to which agencies to contact to arrange staff cover. We were advised the manager had access to a staffing and agency staffing list, and a document showing staffing levels identified which staff in other roles could be redeployed to deliver care in emergency situations.
- There was a cleaning schedule in place, and we saw housekeeping staff carrying out cleaning and hygiene tasks. Where we observed a spillage on the floor, staff took immediate action to disinfect the area. We found a table that was being used by a person to eat and to keep some of their belongings had a build-up of grime. We reported our concerns and evidence was supplied after our inspection to confirm the table had been cleaned.
- We were assured the provider was preventing visitors from catching and spreading infections.
- We were assured the provider was using PPE effectively and safely.
- We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

**Visiting in care homes**

- The home had restrictions in place around the times and duration people could receive visitors.
- However, some relatives raised concerns about restrictions impacting their ability to visit people. Comments included, "Visits pre-booked and in a room, they are quite difficult about that", "I have to book an appointment. Sometimes I have to change that, and they [the service] can't always accommodate", "They [staff] don't let us go in [person's] room. We get there at 4 and they [staff] bring [person] down at 20 past 4" and "We have to meet downstairs in the community hall. You have to book 1 hour slots. We used to go into her [person's] bedroom but not since COVID, which I am very disappointed with, I'd like to go in her room."

The service did not do all that was practicable to meet preferences and needs when facilitating care home visiting. This was part of a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service responded to our feedback and confirmed the concerns we identified would be explored.

# Summary of findings

- The registered manager told us they protected mealtimes but did allow some visitors during this time to share meals with their family member as well as outside of hours.
- One relative advised the service had been flexible due to their personal circumstances. Some relatives told us although restrictions were in place, some accommodation was made. Comments included, “Now I can visit in [person’s] own room, it depends on the staff ratio” and “There are only 4 one hour slots a day and you have to meet in the community room. You have to book in as there is only 1 relative visit at a time, as staff don’t have time to take [person] into the garden, it means I can now, which she enjoys.”

**Reporting incidents and learning lessons when things go wrong**

- Systems did not consistently evidence effective oversight where people experienced distressed behaviours, recorded using antecedent, behaviour, consequence (ABC) charts. ABC incidents were recorded in minimal detail. The registered manager stated the psychologist analysed data when reviewing behaviour plans, care plans and risk assessments, however, no record of this analysis was kept. The provider’s incident recording policy stated incidents of “threatening or violent behaviour faced by staff from service users [people]” should be reported via the incident reporting system. Some ABC incidents had not been documented on incident forms, meaning there was no record of management oversight or staff de-briefs for these incidents, to monitor and analyse people's wellbeing and whether care plans and ways of supporting people were effective.
- ABC charts showed one person was given psychotropic medicine on 8 occasions between January and March 2023. Some entries contained minimal detail, such as describing the antecedent as ‘agitation’, the behaviour as ‘screaming’ and consequence as ‘PRN offered’. There was no further evidence supplied of management oversight or analysis to consider whether staff response to the person’s distress had been effective. The lack of detail in ABC charts meant it would be difficult to conduct a meaningful analysis.
- The quarterly analysis of each person’s accidents and incidents did not consistently demonstrate a meaningful analysis. One person had experienced two skin integrity concerns. A summary of actions was included but the accompanying analysis made no reference to this trend, and did not consider why the person’s skin was vulnerable to breakdown or actions required to maintain the person’s skin.
- Incident and accident analysis was ineffective because it did not include all incidents which occurred. One person’s October to December 2022 analysis failed to include an incident where they sustained bruising to both arms. Another person’s analysis for the same period stated no incidents had occurred, however evaluation notes referred to the person sustaining a bruise and at our request a staff member checked and located records for a fall and an incident of self-injurious behaviour.

Systems were not effectively implemented to monitor events and learn lessons and continually improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager advised the service would improve the recording and analysis of incidents, including those currently documented on ABC forms, through the introduction of an electronic reporting system.
- Regular staff meetings included reflective practice sessions and clinical governance meetings. Recent reflective practice meetings included discussions around communication, completing ABC forms, and how staff should respond to distressed behaviours for some people.
- The service displayed monthly 'lessons learnt' documents to highlight key learning. Staff received feedback on themes such as effective communication, the importance of following the management hierarchy, and reminders for staff to raise any concerns in handover meetings.

**Staffing and recruitment**

# Summary of findings

- Staff recruitment processes did not consistently promote safety. For example, 2 profiles for agency nurse staff members did not include all information required, such as evidence of continuous employment.
- The provider's recruitment policy stated 2 references were required as part of recruitment. However, it did not state whether the expectation was 2 employment or character references. The registered manager told us 1 one employment and 1 character reference was the expectation. This was not a robust approach for the service to assure itself staff were of 'good character'. For example, one nurse had one employment reference which highlighted concerns about their performance and one character reference. Following our visit a second employment reference was provided, however the employment dates provided did not match the nurse's stated employment history and there was no evidence this had been identified or explored. Their interview notes referred to a prior employment concern. After our on-site visit we requested and received a risk assessment in relation to this. We also checked the nurse had no restrictions on their practice.
- Another staff member's personnel file only contained a recruitment agency's interview questions which were basic and did not include relevant values or competencies. The registered manager provided their own interview records after our inspection, and we were satisfied these were suitable for the role. A different staff member did not have a recent photo on file as required.
- Agency staff profiles only listed some training, such as moving and handling and there was no information about whether they received mental health awareness, learning disability and autism, positive behaviour support or de-escalation training, or training to meet people's health needs such as diabetes or Percutaneous Endoscopic Gastrostomy (PEG).

Systems had failed to identify and address concerns in relation to staff recruitment and agency staffing records. This was part of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service did not use a robust dependency calculation to assess or regularly review that numbers of staff matched the needs of people using the service. It was therefore unclear how the provider assured itself that there were enough staff to meet people's personalised needs. The registered manager told us the provider worked on a ratio of 1 to 4 staff which was reviewed annually unless required sooner, and some people received funding for additional 1 to 1 support.
- Staff we spoke with told us they felt there were enough staff to meet people's needs because some people required 1 to 1 support.

We recommend the service implements a tool to ensure required staffing levels are assessed and adapted to people's changing needs.

- Systems were in place to monitor that staffing levels matched expected staff numbers. This included weekly reports and fortnightly meetings with the provider where staffing levels were discussed.
- Records showed agency use had significantly reduced since March 2022 and staff turnover was under the national average.
- The service had reducing vacancy rates. At the time of our inspection there were two vacancies for non-nursing staff, for one chef and one cleaner. The service had completed a successful international recruitment campaign to fill registered nursing posts.
- Levels of sickness were reducing. Managers supported staff who needed time off for ill health. All employees had return to work interviews with the registered manager.
- We observed and records confirmed people received 1 to 1 staffing support where this was funded. A person we spoke with told us they were supported by staff to access the shops weekly.
- Disclosure and barring service (DBS) checks were carried out prior to employment. DBS checks the criminal record of someone applying for the role. The service carried out a criminal check with the embassy of the staff member's country of origin in accordance with good practice guidance.

# Summary of findings

- Completed induction records were on file, however, these were not dated to confirm they were carried out in a timely way. Staff we spoke with told us they received inductions and had time to shadow more experienced staff to prepare for the role and understand people's needs.

**Using medicines safely and clinic rooms**

- People told us they received medicines as prescribed. Feedback from relatives varied as to whether they were involved in discussions about medicines, such as medicines reviews. Comments included, "They [staff] keep me up to date on [person's] medication, update me with any changes" and "If they [staff] review [person's] medication I'm not told. I have said that I'd like to be involved, but they have never engaged with that."
- Records showed the receipt, administration, and disposal of medicines. Staff received training, and their competency was assessed, where specialised medicines support was required, such as for the management of diabetes.
- Spot check audits considered topics such as the accuracy of medicines records and whether correct labelling and storage procedures were followed. We reviewed four recent audits and found where medicines stock was counted, only two audits had checked to verify these matched expected balances. The service provided additional evidence to confirm weekly stock checks were in place, and controlled drugs were checked daily.
- Some people used 'as and when required' medicines. Protocols for pain relief helped staff recognise signs of pain where people were unable to express this verbally. The protocol for one person's use of psychotropic medicine for severe agitation lacked detail as this did not specify what steps should be taken first to ensure the medicine was given as a last resort. The service supplied an updated protocol following our visit to confirm additional detail had been added.
- Clinic rooms were equipped with accessible resuscitation equipment and emergency medicine. Room temperatures were recorded and were in line with national guidance to ensure the safe storage of medicines. However, staff had not always completed thorough checks on some of this equipment. We found pieces of emergency first aid equipment that had been not stored in sealed packaging to ensure they remained sterile. There was also no blood glucose meter in the emergency first aid equipment. Potentially this could delay staff being able to check the people's blood sugar levels quickly in an emergency. We raised these issues on site and staff took action to rectify them immediately.

We recommend the service reviews processes in place to ensure that emergency first aid equipment is checked, easily accessible and stored appropriately.

**Is the service effective?**

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.

We rated this key as requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

**Staff support: induction, training, skills and experience**

- The service did not have policies and procedures in place to ensure regular agency staff received support and reviews of their performance through supervisions. The service was unable to provide evidence about how they were assured agency nurses were working to the expected standards and had the necessary competencies to perform well in their role.

# Summary of findings

- Records from January to March 2023 showed permanent staff received supervisions and appraisals. Staff we spoke with told us they felt supported and received enough training, with comments such as, “Supervision is quite helpful and always awarded supernumerary days and managers assist me with assignments” and “Yes to appraisal yearly and 2 monthly supervisions. Induction was good, staff were so helpful, 2 week induction how it is done, not on the allocation.” A staff member told us the service was supporting them to achieve a vocational qualification.
- The service monitored staff training attendance for mandatory and specific training. We saw evidence of competency assessments for medicines and enteral nutrition. The service had other specific training planned in March 2023.
- Relatives told us they were satisfied staff received sufficient training. Comments included, “New staff are brought in and trained. The training is done in a range of ways. I can see some topics on the board for training”, “The ones [staff] I’ve met definitely get the training [person] needs to support him” and “Yes they are well trained as they deal really well with residents [people’s] behaviours.”
- Managers supported registered nursing staff to complete the revalidation process.
- Permanent staff had completed training in mental health awareness, supporting people with learning disabilities and autism and positive behaviour support. However, staff may have benefited from formal training to further develop their specialist skills and knowledge around mental health rehabilitation.

**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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Mental capacity decision making was not documented where people could not consent to COVID-19 and flu vaccines, and required a representative to consent on their behalf.
- The DoLS authorisation for one person stated the service should complete MCA and best interest decisions for all restrictive practices in place such as 1 to 1 support and medicines. The person received as and when required psychotropic medicine. Records for a ‘care and treatment’ decision made general reference to ‘constant supervision’ and did not refer to how medicines would be administered in the person’s best interests.
- We observed one person’s hands and arms were held by a member of staff to enable a nurse to administer medicines. The nurse also described a similar hold was required for another person’s medicines support. We checked both people’s records and found no evidence people’s capacity to consent to these restrictions had been explored or agreed in people’s best interests.
- Best interest decision making did not meaningfully weigh the potential risks and benefits of options considered. For example, one person’s best interest decision did not consider risks in relation to their privacy as a result of 1 to 1 staff monitoring.
- Staff received and kept up to date with training on the Mental Health Act. However, individual staff knowledge and understanding of the Act and Code of Practice varied. For example, we were told by some staff that the service did

not have any people admitted to the service on an informal basis (informal means people are receiving mental health treatment voluntarily). However, we found there was at least one person staying at the service informally at the time of our inspection. Although this hadn't directly impacted people's care it demonstrated a lack of understanding.

We recommend the service seek advice from a reputable source in relation to the requirements of the Mental Capacity Act 2005, to ensure the service can demonstrate how they put these into practice effectively, and ensure that people's human and legal rights are respected.

- Mental capacity assessments for some specific decisions had been appropriately documented, such as for the use of coded and locked doors. These considered whether people could understand, retain, weigh up information and communicate a decision.
- The service submitted applications where DoLS authorisations were required. Applications were monitored via a tracker and progress chased as required.
- We observed examples of staff seeking people's consent before offering support. For example, in one lounge we observed staff asking people where they would like to sit for lunch before assisting people to the dining table who wished to eat there.
- Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. Staff stored copies of detention papers and associated records correctly and staff could access them when needed. Managers completed Mental Health Act audits to ensure paperwork was correct.
- People using the service had access to information about independent mental health advocacy. Staff explained to each patient their rights under the Mental Health Act. They reminded people of their rights at regular intervals and recorded this clearly in the patient's notes each time.

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

- People's records did not always reflect their dietary needs. For example, one person's care plan did not make any reference to fortifying meals which staff told us and records showed were in place for the person. No malnutrition screening records and weight checks were made available. Fluid charts for the same person included written notes from staff stating to be careful not to over-hydrate the person as it is a clinical risk. We were concerned this was not relevant to the person whose risk assessment and care plan did not identify a clinical risk and it should not be a concern where people's minimum target is exceeded by an insignificant amount.
- Another person was assessed by a speech and language therapist as requiring 1 to 1 supervision and a regular soft diet. The person's care plan referred to two different types of food textures. The care plan noted the person was at risk of choking due to rushing food and required '1 to1 supervision'. The care plan did not specify how staff should intervene if the person was rushing. Staff feedback indicated the person was at times physically supported to eat, however this level of assistance was not reflected within the care plan.
- The service made referrals to speech and language therapy and dietitian support where needed. A relative noted, "They [staff] got a specialist speech therapist in who tested his swallow. I'm told his eating is much better and he's putting on weight." Records for one person showed staff had inconsistently followed their dietician plan relating to breakfast portions. A supervision was held with staff in response to our feedback.
- Kitchen staff were informed about people's dietary needs including allergies, food textures and cultural needs. A four weekly menu was in place. Staff supported people to indicate menu choices in advance. People with diabetes received an appropriate diet and staff were aware of a person's food intolerance. One person received meat in line with their religion and vegetarian food was available. One relative told us culturally familiar food was not always given, commenting, "I don't know if [person] enjoys it, it's very different to home food. I take home cooked food when I go."

# Summary of findings

- People could express opinions about meals at resident meetings. We received variable feedback from people, one person described the food as "very good" and two people told us they would like a wider variety of choices offered. Relatives advised, "The menu changes after 4 weeks. They gave me a copy of the menu so I could tick off what he doesn't like" and "He gets plenty of food and it's balanced."
- People had access to water in their bedrooms and each unit had dispensers for squash. Each unit also had a locked kitchen which people could access with staff supervision.
- We saw some staff responded to requests for sandwiches and hot drinks between meals, and at lunchtime staff patiently supported and encouraged food intake. On another unit we identified a concern in relation to a form of physical restraint used during a mealtime which we commented on within the Safe section of this report. On the same unit we observed a person balancing their plate of food on their chest and stomach area. The table was not well positioned for them to reach.

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

- Staff held daily meetings, including handover meetings, to share updates about people's needs. Systems were in place to ensure staff understood their responsibilities, such as allocations for 1 to 1 support, first aid, fire marshal duties and observation checks.
- Ward managers provided positive feedback regarding teamwork and support from care staff. A ward manager commented, "[Staff] communicate well, don't let things go, they respond very quick, they do take note."
- Care records showed the service referred to external agencies for healthcare support. These included neurology, tissue viability nurses, GP, chiropody, physiotherapy, psychiatry, dietetic services, speech and language therapy and specialist nurses for conditions including diabetes.
- People had access to GP support and staff could access medical advice 24 hours per day using an electronic device. One person told us they made staff aware they had a sore toe and explained the doctor visited the same week and prescribed antibiotics.
- Most relatives were satisfied staff contacted healthcare services appropriately when health concerns occurred, with comments including, "He fell and bumped his head. This head injury seemed minor, but they sent him to hospital." Some relatives expressed concern around whether health issues had been identified and acted upon quickly enough. A relative advised, "I could hear her chest rattling. I insisted she see a doctor and it turns out she had a chest infection."
- At the time of our inspection, the onsite multi-disciplinary team had the required specialists in place. A consultant psychiatrist and clinical psychologist were in place to support service users' mental health needs. Staff worked with external professionals, for example dieticians when needed. The occupational therapist post had been vacant from August 2022 to February 2023. The service had made attempts to recruit to this post and had successfully appointed a new occupational therapist a few weeks prior to our inspection. An activity coordinator had continued to offer some activities including escorted trips to the supermarket.

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

- Some people received care on mixed-gender units. The ground floor supported male and female people on separate units. We found no issues relating to mixed sex accommodation on the floor above.
- Easy read signage was in place for people this would benefit, such as those living with dementia.

# Summary of findings

- The service generally appeared clean and hygienic with no malodours. People benefited from en-suite bathrooms and were able to personalise their rooms. Some areas of the environment required updating. On one unit we observed a microwave with a rusted interior and some areas of flooring were worn. Another person's flooring had a gap which was addressed in response to our feedback, and we were made aware flooring would be replaced as part of ongoing works.
- During our visits at times we heard loud work, including drilling to fix a burst pipe, use of a cement mixer situated beneath a bedroom window and an excavator. People and relatives provided variable feedback regarding the impact of noise. Comments included, "The drilling was awful but that's happened now. Drilling was associated with his hallucinations", "It was quite loud when I last went but it didn't bother him" and "The renovation is taking a really long time, there is a lot of noise and building work, the garden is a mess."
- The lounge on one unit was not protected for people's use and was in use for staff training on the first day of our inspection. Staff, including a ward manager, told us the lounge had previously been used for training, meetings and could be booked for family visits. People shared the communal lounge on a connected unit, where on the first day of our inspection, several people were trying to engage in activities such as watching TV, playing games or having quiet time to read a newspaper. The registered manager told us some people with capacity chose to use this lounge and stated people did at times access the other lounge for meals or specific activities.
- There was no designated multi-faith room for people using the service to access. The multi-faith room had been converted into staff offices. Staff would provide people with resources if they wished to practice their faith and said a lounge could be reserved for this purpose.

We recommend the service review the care environment to ensure it is designed and adapted to a consistent standard, to provide a therapeutic environment which promotes independence, accessibility and meets people's individual preferences, and cultural and support needs.

- Some people's rooms were personalised. The registered manager explained families were encouraged to bring in photos and items to use in memory boxes. One person showed us their bedroom was decorated with photos of interest to them, printed by the activities coordinator.

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

- People's needs were assessed either prior to the delivery of care or on their arrival at the service. An initial assessment explored people's physical, social and mental health needs, also identifying areas of risk. We found some initial assessments had not fully explored all aspects of people's needs, such as sensory needs, COVID-19 vaccine status and sexual orientation.
- The service used recognised best practice assessment tools including those to identify risks in relation to malnutrition, skin breakdown and oral health.
- We found some examples where the service used technology to support the delivery of effective care and support. For example, some people used low profile beds with crash mats to reduce the risk of injury from falls. An occupational therapist (OT) was recently employed. The registered manager explained equipment recommended by the OT would be purchased by the provider.
- Staff supported people with their physical health and encouraged them to live healthier lives. Staff made sure people had access to physical health care, including specialists as required. People were given access to resources and advice on living healthier lifestyles including smoking cessation.
- Staff had used recognised rating scales to assess and record severity and outcomes. This included HoNOS (Health of the Nation Outcome Scales), a method of measuring the health and social functioning of people with mental illness. A clinical psychologist was available to work with people receiving care through the mental health rehabilitation pathway.

# Summary of findings

**Is the service caring?**

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

We rated this key question as requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

**Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence**

- The language used in people's records to describe people did not promote equality values. One person's care plan repeatedly stated they 'suffered' from conditions including a learning disability. Other records described people as 'suffering from mental and physical health conditions'. Best practice guidance suggests phrases such as 'suffers from' should be avoided as this suggests discomfort, constant pain and a sense of hopelessness.
- Records referred to people as 'disruptive', 'wandering', having 'outbursts' or making 'demands'. One person's care records described them as 'challenging' and stated, 'I become demanding and non-complaint' advising staff to, 'set some boundaries to my demanding requests' without further details or explanation.
- One person's behaviour plan referred to their involuntary movements as a 'behaviour' and advised staff, "Remember I cannot reflect on unacceptable behaviour and cannot learn from it", without specifying what 'unacceptable' behaviour this referred to. The clinical director confirmed there had been no incidences of 'behaviours that challenge' for the person. This meant there was a risk staff may associate the person's uncontrolled movements as 'unacceptable' behaviours.
- One person's dietary needs were displayed in a communal kitchen. This was not respectful. The registered manager removed the document in response to our feedback.
- We observed mixed positive and negative staff interactions with people. For example, for a duration of approximately an hour we observed a person's 1 to 1 staff support did not smile or respond to the person with warmth. The person showed signs of distress such as crying and shouting and continually threw or pushed away the activity the staff was looking at with them. Later we observed another staff member supporting the person, the staff member appeared friendly and was chatting with the person. The person responded positively, was smiling, appeared engaged and calm.
- We observed another staff member following a person around the lounge as they tried to take other people's drinks. There was no offer of an activity to engage the person or distract them. The same person was shouting which contributed to the noise levels in the room and we saw staff made no effort to ensure a calm or therapeutic environment for others.
- Some aspects of the environment did not maintain peoples' privacy. Some people had fish-eye observation holes in their bedroom doors. These had originally been installed to allow staff to make observations on service users without disrupting them but could have been used by others to view inside their room. This did not meet national guidance on viewing panes in mental health services, which advises bedroom doors should have a vision panel to allow staff observation into the room with a means of obscuring the panel, controlled by the patient but with staff over-ride. Managers told us there had been no reported incidents where a person had tried to use these to look into a service user's room.

The service did not always ensure people were consistently treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Summary of findings

- People told us staff treated them well. People's comments included, 'All carers very kind and efficient, staff gentle and they always draw the curtain [for personal care]" and "Staff can be helpful, have a laugh, can talk about what you want." Relatives added, "When I visit, they always ask if we want to be left alone" and "Staff are always friendly. It's a nice, warming place."
- Feedback from people indicated independence was promoted. One person said, "If [I] can do myself let me do myself, if [I] can't they [staff] help me. They are sensitive to my needs." We were advised care plans would be updated.
- A ward manager explained they reminded staff to sit down when assisting with meals to avoid rushing people. We observed staff gently wake someone by stroking their hand, ask where they wanted to eat, and patiently assist with their meal.
- People using the service could make phone calls in private.

**Supporting people to express their views and be involved in making decisions about their care**

- Care records did not consistently evidence people, or their representatives, where appropriate had been involved in developing their plan of care.
- Comments from people's relatives in relation to care planning included, "I wasn't involved in her care plan", "I haven't been but yesterday I was involved over the phone" and "I've asked if they do formal meetings and reviews, but I just want it to be more like teamwork. I have seen a care plan."
- Some relatives told us they could express their views but described concerns about communication and responsiveness. Comments included, "One time I asked for a list of their medicines and I got it eventually, and it took 3 months to answer the request to take [person] out but they said they couldn't provide cover to support me" and "I asked why [person] was losing so much weight, and staff couldn't answer as they couldn't understand me. You get no feedback".
- One person's records stated there were no concerns identified around using CCTV. We observed the person received their food and medicines through the percutaneous endoscopic gastrostomy (PEG) in a communal lounge where other people were present, and CCTV was in use. There were no records that considered how the person's privacy could be protected.
- Staff said people receiving care through the mental health rehabilitation care pathway did not always wish to engage in the care planning process and they recorded this. We also observed staff taking the views of a service user into consideration when discussing their care and treatment. However, when service users chose not to engage in the care planning process, staff had not always ensured care records were still written in a person-centred way. For example, some wording included in individual care plans did not reflect the service user's voice.

The service failed to consistently involve people and their representatives in decisions about their care. This was part of a breach of regulation 9 of the health and Social Care Act 2008 (Regulated Activities) regulations 2014.

- People were offered access to advocacy. An advocate visited the service weekly and described their role as supporting people to understand their rights and support them to have a voice in relation to their care. People's records we reviewed did not evidence the impact of advocacy support, however the advocate confirmed the service responded to their feedback, advising they were pleased with how staff responded to requests from people.
- Relatives were invited to family meetings where updates were provided and there was an opportunity to share feedback. Regular newsletters provided helpful information to families such as contact information for the local GP surgery and updates about the provision of services such as dental care.

**Is the service responsive?**

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

# Summary of findings

We rated this key question as requires improvement. This meant people's needs were not always met.

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

- Care records included some references to people's protected characteristics, but this was inconsistent. For example, two people's care records contained blank spaces in relation to their religion. Care plans included goals, although these were generically worded and did not appear personalised to what was important to individuals. One person's goals included general statements such as "Remain safe and prevent risk to others".
- People's sensory needs were not fully assessed to promote personalised care. For example, one person's behaviour plan indicated they may find it upsetting to be in the dark and records described occasions of distress overnight. Their care plan for sleeping did not provide guidance regarding preferred lighting levels and the registered manager advised the light was switched off at night. Following our visit, a revised care plan stated staff should 'perhaps' leave a light on.
- Positive behaviour support (PBS) plans contained insufficient detail to support staff to provide personalised care. For example, one person's mental health review referred to triggers for emotional upset including a lack of contact with family. Their PBS plan did not include reference to proactive support strategies regarding the identified triggers. The plan stated the person becomes agitated if 'pad is soiled', however, there was no direction about ensuring regular personal care or how to respond.
- Communal spaces were not always optimised to enable all people to enjoy activities. For example, we observed loud music played in the communal lounge to meet someone's personal preference, however, this was very audible when seated next to the TV which five other people were trying to watch. One person commented, "Shut that noise off will you" and a staff member responded by saying, "It's not very loud". Whilst the staff member's comment appeared to be offered as reassurance, the competing noises did not provide a relaxing atmosphere for people using the lounge.
- Some aspects of care plans were not always personalised, holistic and recovery-orientated. For example, personal behavioural support (PBS) plans did not always reflect the service user's voice and contained pre-written phrases. Some plans relating to people's mental health did not demonstrate collaborative care planning.
- Staff had not completed detailed discharge care plans for people receiving treatment through the mental health rehabilitation care pathway. Records that had been kept in relation to discharge did not demonstrated how staff had actively planned and considered discharge for each person. This did not meet best practice standards described by the National Institute for Health and Care Excellence (NICE) and other relevant organisations.
- An activity coordinator had continued to offer some activities in the absence of an occupational therapist. For example, some service users had been supported to visit car boots and the local shops, another completed weekly arts and crafts, facilitated by an external visitor. However, service users had not accessed other regular activities that may have promoted self-care and supported them to re-visit wider independent living skills.
- Staff did not proactively support people with accessing activities outside the service, such as work and education opportunities as part of their rehabilitation journey. In addition, at resident meetings from December to February, some people had requested external trips, but the service had said this was not possible due to the 'cold weather'.
- People's relatives indicated activity provision could be improved, with comments including, "There is no stimulation" and "There is nothing to do. There is a corridor and a lounge with a TV, there is entertainment, but it is very basic." One person told us they would like a greater variety of activities and another person explained the choice of entertainment, such as musical styles, was not to their taste.

The service did not consistently provide personalised care and support to meet people's holistic needs. This was part of a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Summary of findings

- Staff we spoke with, who provided 1 to 1 support, could describe people's needs. One person's allocated staff member was aware they could become distressed by noise from others and explained techniques used to divert the person's attention.
- Relatives told us the service responded to changing needs for people living with degenerative illness. A relative advised, "The condition is degenerative so things are getting worse…they encouraged him to be with other people but they let him stay in bed now when he wants."
- We observed some people engaged in activities. These included listening to music, television, reading newspapers, board games, kicking a football in the corridor and one person had their nails painted. The activities schedule confirmed external entertainment was booked to attend the service and events were held for special occasions, such as a summer barbeque.
- Resident meetings included a discussion about preferred activities. For example, people expressed at a meeting they had welcomed the opportunity to go shopping before Christmas.

**Meeting people's communication needs**

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care records identified their ability to communicate verbally. One person's care plan referred to them wearing glasses which staff advised was incorrect and following our visit it was confirmed the person had not required glasses since March 2022. Another person was unable to communicate verbally. Their behaviour plan suggested staff use 'pictures, gestures, symbols' without further explanation about how these should be used.
- Some people required aids to support their communication. One person's records showed their family identified in October 2022 their glasses had been lost. Care records contained no evidence of follow-up. Following our visit we were advised the service had been in contact with an optician in March 2023 and an appointment was booked.
- A person told us they were unhappy about their broken glasses and asked us to tell staff about it. The glasses the person was wearing were covered in tape to hold them together and obstructed the person's visibility. The registered manager provided records and showed us another pair of glasses had been purchased but the person chose not to wear them. In response to the person's request, we asked the registered manager what else had been done to resolve this, however, we received no response during our inspection. After our inspection the registered manager told us they were working with the person to introduce their new glasses, and to dispose of the old pair, due to the associated risk of using the glasses which were taped up.
- There was no evidence of sensory assessments to identify and respond to people's needs. For example, one person's PBS plan stated that noise and busy environments worried them or made them feel anxious, however there was no evidence of a sensory assessment in response to this information. When we asked a staff member about how they supported the person's sensitivity to noise they stated, "[Person] is not sensitive to noise levels. [The person] listens to high volume music in their room." This showed that staff did not fully understand the person's needs to support them well and avoid distress.

The service did not ensure people consistently received personalised support to meet their communication needs. This was part of a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- An accessible information policy was in place which outlined how people's communication needs should be identified and met. We observed some easy-read signage in place, such as a complaints poster and a poster informing people how to contact CQC.

# Summary of findings

- We observed some examples of staff communicating with people effectively. For example, we found the activities coordinator had a good rapport with people, such as engaging with someone to help them read a newspaper.
- Relatives told us some staff knew people well and this helped to facilitate positive communication. A relative advised, "One or two staff know him [person] really well and talk to him really well. Most of the time nobody understands him, particularly if he's hallucinating, but the regulars know what he likes."

**End of life care and support**

- We saw an example of a care plan for a person who recently passed away which reflected their end of life wishes had been explored.
- An end of life care policy was in place, and staff were offered training in relation to death and bereavement and end of life care.
- Records showed the service had received positive feedback about end of life support. A relative stated, "May I say how very grateful we are for the gentle, professional and compassionate care you and your colleagues gave to our [person]] in those last few months. [Person] was the most settled and well cared for that we have seen for many months."

**Improving care quality in response to complaints or concerns**

- Relatives told us they had received information and knew how to complain if required. People's right to complain and raise concerns was highlighted via an easy-read poster.
- The service treated all complaints seriously and investigated them. People received a formal acknowledgement of their complaint and further correspondence to confirm the outcome of the internal investigation.
- A complaints log noted whether complaints were upheld, and the registered manager provided their thematic analysis for 2022 which identified lessons learnt in relation to keeping inventories of belongings and discussing with relatives any changes in care.

**Is the service well-led?**

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.

We rated this key question as requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- We identified 5 breaches of regulations that had not been identified by the provider's own quality assurance processes. This meant our findings from the other key questions demonstrated that governance processes did not always operate effectively and that performance and risk were not always managed well.
- Sufficient policies, processes and systems had not been in place to ensure national legislation and best practice around restrictive practice, including restraint were met. Use of restraint was not always recognised and recorded by staff. People were sometimes subject to restrictive practices by staff who had not received sufficient training. Guidance was sometimes unclear as to how staff should support service users.

# Summary of findings

- Governance processes had failed to effectively identify or address concerns around people's records such as DNACPR authorisations for some people which were not in line with recognised best practice. Three people's authorisations did not follow best practice, either because the forms did not evidence how the person or their representative had been consulted, or because the reason given that CPR should not be attempted lacked sufficient detail, such as stating CPR was unlikely to be successful due to 'co-morbidity'. In response to our feedback the service contacted the GP surgery to review the authorisations.
- Care records were not consistently accurate, fully completed or appropriately updated. For example, one person's risk assessment contained inaccurate information about their status under the Mental Health Act, two people's records referred to a type of staff de-escalation training which the registered manager told us was no longer in place, and one person's care records referred to them using both glasses and dentures which staff advised was inaccurate.
- Provider auditing identified some areas for improvement, however, these audits had not been effective in identifying all of the concerns we found. A recent internal inspection report had not identified concerns in relation to positive behaviour support (PBS) plans and described these as "detailed and reviewed in a timely manner." We found there was no recorded evidence of people's involvement or involvement from their relatives or other MDT professionals in these plans. This was not in line with the provider's policy and the policy did not reference the need for mental capacity and best interest decisions in relation to PBS plans.
- Audits of care records had failed to identify the concerns we found in relation to the language used to describe people, examples we found of inaccurate or incomplete records, and the absence of evidence within care files of people's and families' input in care planning, including for positive behaviour support plans. Auditing and governance systems had also failed to identify and address the concerns we found in relation to recruitment and agency staffing records.
- The service had failed to ensure the CCTV system equipment was kept secure at all times. The equipment was stored within a cupboard with three sets of wooden doors. On 15 and 20 March 2023 we found the cupboards were not fully secured. This meant there was the potential risk of unauthorised access to the equipment. The service carried out maintenance works in response to our feedback to fix the faulty door locks.
- A business continuity plan (BCP) was in place to consider the welfare of people when emergencies occurred. The plan lacked sufficient detail and some risks had not been fully considered. For example, the BCP referred to the predicted winter energy crisis and the registered manager explained following a previous outage a generator was on order. The current plan did not refer to how disruption for people who used hoists and hospital type beds would be managed if an electric outage occurred.
- Leaders did not always demonstrate up to date knowledge about elements of the mental health rehabilitation care pathway. The registered manager and clinical director were unaware of their responsibilities under the Mental Health Units (Use of Force) Act 2018. There was no restrictive interventions reduction programme which is a statutory requirement in place for the service at the time of our inspection.
- Leaders had not embedded a structure approach to ensure continuous improvement and innovation. Staff had not been trained in quality improvement methods. There were no quality improvement projects taking place within the service at the time of our inspection. The service had not participated in accreditation schemes relevant to the mental health rehabilitation service, such as the Royal College of Psychiatrist AIMS Rehab accreditation scheme for inpatient mental health rehabilitation services. Managers had not benchmarked with similar services. This may have led to missed opportunities for service improvement and learning.
- Managers did not evaluate the effectiveness or measure specific elements of mental health service quality, for example discharge planning or auditing against specific National Institute of Health and Care Excellence (NICE) guidelines applicable to the service. They had not used benchmarking and quality improvement initiatives specific to mental health rehabilitation to assess how effective the service was or consider areas for improvement.

# Summary of findings

Systems had not been operated fully effectively to assess, monitor and improve the quality and safety of the services. The service had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us they were well supported by the provider, including regular supervision. The registered manager and director of clinical services told us they had access to ongoing learning and development opportunities.
- The service held regular staff meetings, clinical governance meetings and reflective practice sessions which contributed to lessons learnt information for staff. Minutes demonstrated that management provided open and constructive feedback, updating staff about expectations in areas such as updated PPE guidelines and confidentiality. Clinical governance meetings openly discussed topics such as the outcomes from audits, staff training, clinical effectiveness and updates in relation to safeguarding and observations from manager walkarounds.

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

- Staff provided positive feedback about support for their roles. A staff member advised, "Built a good team, always try to help each other, if any concerns always have open door policy with hospital director." Another staff member referred to the registered manager and clinical director, advising, "If anything on mind I know I can go to them, will help with anything, everyone gets supported." A third staff member commented, "I'm really happy to work here and if don't understand [can] ask nurse or managers always happy to assist and give training."
- A culture of celebrating staff good practice was promoted. Recognition initiatives included free meals once a week, events such as a Christmas function, employee of the month and a yearly awards scheme. This formed part of work to maintain a stable staffing team, and the service reported a low staff turnover rate.
- People and their relatives provided some positive feedback about the service and management approach. Family comments included, "I like the atmosphere there. [Person's] much more relaxed now", "The manager runs a tight ship and has the right attitude" and "I find it very supportive, they manage to make it feel home-like."
- Some relatives raised concerns about poor communication. Some of the comments included, "I leave messages but I'm never sure if they get through. I don't get any updates about how [person] is", "If I need to speak to someone I go to the nurse. I have no way of knowing if information is being processed or acted on" and "I wasn't told when [person] had COVID, I rang to arrange a visit and was told then. They never let me know anything." One relative provided positive feedback about communication with the registered manager, advising, "[Registered manager] always responds to my emails, she is polite...she has always been helpful to me."

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

- Monthly meetings were held with people using the service. Meetings provided an opportunity to discuss subjects such as food, activities and people's general feedback about the service.
- Regular family meetings were held which provided an option to attend virtually. Minutes reflected feedback was sought in subjects such as activities and the newsletter contents. Comments included, "They do have regular meetings, they send out a newsletter and you can get involved in zoom relative meetings" and "I do get an on-and-off email telling me about online meetings, which is hopeless to me at my age."
- The service displayed 'You Said, We Did' posters to show how feedback had been acted upon. The most recent poster advised due to difficulties reaching units by telephone, the system was upgraded to enable callers to choose the unit they wished to speak to.

# Summary of findings

- Surveys had been offered to people using the service in February and September 2022. The registered manager shared the results which included actions to address areas where feedback was less positive.
- Surveys had also been offered to relatives in February and September 2022. A total of three completed surveys had been returned which provided positive feedback. The registered manager explained ongoing efforts were being made to encourage families to complete the survey, including the option to leave surveys anonymously at the reception desk.
- A newsletter had been developed as part of a strategy to engage with families. Meeting minutes reflected there had been positive feedback in relation to the newsletter. At a recent family meeting a relative commented, "[It's] perfect, I personally love going through all the pages and I look forward to have one every month."
- The registered manager provided examples where staff feedback had been acted upon. For example, preferences about the weekday for free staff meals had been accommodated. The registered manager also explained staff arriving from overseas were listened to and supported to adapt to life in the UK. New arrivals received a 'welcome pack' and a staff ambassador was appointed to support staff to adjust to life in the UK.

**Working in partnership with others**

- Local community resources were not always used to support people's recovery journey. This included local education providers, and volunteer organisations that could offer support to service users in developing independent living skills.
- Professional stakeholders were offered a questionnaire in February and September 2022. The uptake was low although the feedback received from one professional's response was positive.
- One professional commented, "We work in partnership to provide safe effective care. They always follow the care plans I put forward and contact me regularly for support and if they have concerns." Another professional told us communication could be improved, advising, "Sometimes I have found it difficult to contact staff regarding the service user's care. I have either had a delayed response via email or am unsure of who to contact due to lack of communication."

**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**

- A duty of candour policy was in place. The policy did not correctly define the harm thresholds which trigger a notifiable safety incident under the regulation. The policy referred to the criteria for an NHS trust, not the criteria for a "notifiable safety incident" applicable to other services.
- Most relatives told us they were informed and received feedback when incidents occurred. Comments from one person's family included, "He did a lot of self-harming. They [staff] would always tell me" and "He fell over and I was told quite late at night but they shared it with me." Another person's representative expressed concern they had not received information following a person's injury.
- The registered manager described their commitment to being open and honest in their approach. Feedback in relation to duty of candour responsibilities had been discussed during a November 2022 clinical governance meeting and during meetings staff received feedback where lessons had been learnt from complaints and safeguarding concerns.

# Summary of findings

## Contents

# Summary of this inspection

## Background to Apple Hill

Apple Hill is registered to provide accommodation for persons who require personal or l nursing care, treatment of disease, disorder or injury and assessment of medical treatment for persons details under the Mental Health Act 1983. The service can accommodate up to 42 people. At the time of this inspection 3 people were receiving treatment within the long stay mental health rehabilitation service. 39 people were residents using of the care home with nursing service.

The location is split into 3 units situated across 2 floors:

- Walbury unit is the ward that provides care can treatment for up to 7 men. At the time of our inspection, 2 people staying on this ward were receiving care under the mental health rehabilitation service. The remaining 5 beds were used to provide care and treatment to people receiving nursing care.
- Regatta is a female only unit with 14 beds. Most people staying on this ward were receiving nursing care. There was one person receiving mental health rehabilitation care. The unit was split into two areas, Tedray and Regatta.
- A further 21 beds for people requiring nursing care were provided upstairs on Russel unit which was split into two areas, Russel and Hurley.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

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. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

**What people who use the service say**

We received limited feedback from people living in the long stay mental health rehabilitation unit and people close to them. We received feedback from 1 patient during our inspection and no feedback from family members or carers of the 3 people using the service. For people receiving nursing care, we spoke with 15 relatives. We spoke with 8 people and where people were unable to speak with us, we spent time observing people's behavior and body language to help us understand their experiences of using the service.

Our observations during inspection showed mixed positive and negative staff interactions with people. We saw staff communicating and supporting people in a friendly way and taking their opinions into consideration. We also saw instances where staff did not proactively engage or responded to people with warmth to meet their needs. We received feedback from external stakeholders and their feedback was largely positive and they observed positive relationship between staff and service users. However, some concerns about the environment, communication and effective discharge planning were raised.

# Summary of this inspection

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions;

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We visited the service over 4 days on the 15, 20, 28 and 30 March 2023. We also completed some inspection activity off site, such as telephone interviews.

Due to the service's regulated activities and different care pathways the inspection team comprised of 2 adult social care inspectors, 2 mental health inspectors, a specialist advisor (a registered nurse) and 3 Experts by Experience

On the 15 March 2023 an inspection manager and additional Expert by Experience joined the inspection as part of a pilot project to improve how we use observations during inspections.

During the inspection, the inspection team:

- toured the service,
- spoke with 8 people that used the service and attempted to engage with 5 others,
- spoke with 15 relatives and/or carers of people that use the service,
- interviewed 10 staff, including nurses, support workers and ward managers,
- interviewed the registered manager and the clinical director for the service,
- spoke with members of the team including the clinical psychologist, occupational therapist, and activity coordinator,
- spoke with external stakeholders and gained their feedback on the service,
- reviewed care and treatment records relating to 10 people who used the service,
- reviewed policies and other documents relating to the running of the service,
- made observations of the environment and how people were supported. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Areas for improvement

**Enforcement and Recommendations**

We have identified five breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding and governance.

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

# Summary of this inspection

We have identified breaches in relation to the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

**Regulation 9 Person-centred care:**

- The service failed to facilitate visiting arrangements to ensure people's preferences and needs were consistently met.
- The service failed to consistently involve people and their representatives in decisions about their care.
- The service did not consistently provide personalised care and support to meet people's holistic needs. This included support to meet their communication and nutritional needs.

**Regulation 10 Dignity and respect:**

- The service did not ensure people were consistently treated with dignity and respect.

**Regulation 12 Safe care and treatment:**

- Systems had not been effectively operated to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

**Regulation 13 Safeguarding service users from abuse and improper treatment:**

- The service had failed to operate effective systems to effectively protect people from risk of abuse, including unnecessary or disproportionate restraint.

**Regulation 17 Good governance:**

- Systems were not effectively implemented to monitor events and lessons learnt to continually improve the service.
- Systems were not fully effective in assessing, monitoring and improving the quality and safety of the service provided. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user.
- Systems had failed to identify and address concerns in relation to staff recruitment and agency staffing records.

We also made the below recommendations for the provider. These are actions the provider should consider taking to prevent it failing to comply with legal requirements in future, or to improve services. These reflect something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- We recommend a regular reviews of staffing levels are in place so these can adapted to people's changing needs.
- We recommend the service seeks advice from a reputable source in relation to the requirements of the Mental Capacity Act 2005 and puts these into practice effectively to ensure that people's rights to make own decisions are respected.
- We recommend the service reviews the environment to ensure it is designed and adapted to provide a therapeutic environment to promote independence, accessibility and meet people's individual preferences, and cultural and support needs.

# Summary of this inspection

- We recommend the service reviews processes in place to ensure that emergency first aid equipment is checked, easily accessible and stored appropriately.

**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 continue to monitor information we receive about the service, which will help inform when we next inspect.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Overall** | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>• The service failed to facilitate visiting arrangements to ensure people's preferences and needs were consistently met.<br>• The service failed to consistently involve people and their representatives in decisions about their care.<br>• The service did not consistently provide personalised care and support to meet people's holistic needs. This included support to meet their communication and nutritional needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>• The service had failed to operate effective systems to effectively protect people from risk of abuse, including unnecessary or disproportionate restraint. |

| Regulated activity | Regulation |
|---|---|
| Accommodation and nursing or personal care in the further education sector<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>• The service did not always ensure people were consistently treated with dignity and respect. |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**S29 Warning Notice**<br><br>Systems had not been effectively operated to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**S29 Warning Notice**<br><br>• Systems were not effectively implemented to monitor events and lessons learnt to continually improve the service.<br>• Systems were not fully effective in assessing, monitoring and improving the quality and safety of the service provided. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user.<br>• Systems had failed to identify and address concerns in relation to staff recruitment and agency staffing records. |