Fulfilled Living Limited

Jabulani

Inspection report

36-38 Waterside
Hadfield
Glossop
Derbyshire
SK13 1BR

Tel: 01457239286
Website: www.fulfilled-living.co.uk

Date of inspection visit:
18 February 2020

Date of publication:
04 June 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Jabulani is a residential care home providing accommodation and personal care for people with learning disabilities, autism, physical disability, mental health conditions and sensory impairment.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 11 people. Eight people were using the service. This is larger than current best practice guidance.

People's experience of using this service and what we found
Practice at the service placed people at risk of harm. We found the building was cold throughout the inspection and the hot water in some people's bathrooms did not reach suitable temperatures. Where people and relatives had raised concerns of inappropriate care or treatment, these were not always followed up or investigated. People did not always receive their medicines as prescribed. Safeguarding was not always given sufficient priority. We found examples of people telling staff or management they had been verbally or physically abused. These had not always been investigated. The provider could not demonstrate that staff had been safely recruited.

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

The service rarely applied 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, lack of choice and control, limited independence and limited inclusion.

Care and support plans did not reflect the most recent evidence-based guidelines or best practice guidance. Staff were not adequately trained, and some did not have the skills or competency required. There was not always bespoke training to teach staff how to meet people's individual needs. For example, where people had certain health conditions or autistic spectrum disorder, staff had not received training to meet their individual needs.

Privacy and dignity were not respected, this included when people were asleep. People's independence was not promoted. People were not supported to enhance their life skills. For example, they could not go into the kitchen unless staff unlocked the door for them. The provider did not make independent advocacy available to people. The registered manager showed a lack of understanding about independent advocacy. Staff were instructed to be task focused and companionship was not promoted.

People did not have choice and control of their own lives. People had restrictions on their freedom that were

not assessed and had not been agreed as in their best interest. People were not always supported to follow their interests or to take part in activities that were relevant to them. Visiting restrictions had been put in place on relatives and people who had raised concerns had been told they were no longer allowed to enter the premises. This meant some people were unable to spend time with their families in the home. The provider's response to complaints did not demonstrate they took people's complaints seriously and treated them with equality.

People told us the service was not well-led. There were low levels of staff satisfaction and the provider did not demonstrate an understanding of the importance of promoting people's human rights. This meant people's needs were frequently overlooked. Staff told us the newly appointed registered manager offered them more support than they had experienced before but staff, relatives and some professionals raised concerns with us about the conduct and manner of other senior members of the management team. Feedback we received was that people, staff, relatives and professionals at times felt intimidated, victimised and bullied. Systems and processes to assess, monitor and improve the quality and safety of services provided were ineffective.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 03 October 2019)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulations. We have used the previous rating and enforcement action taken to inform our planning and decisions about the rating at this inspection.

The service remains in special measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding people from abuse and improper treatment, handling of complaints, good governance, staff training and recruitment of staff at this inspection. In response to this we served notice of our decision to cancel their registration with CQC. This action has now been completed and the provider is no longer able to provide accommodation for people who require nursing or personal care from this location.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Jabulani

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors and a learning disability nurse specialist advisor.

Service and service type
Jabulani 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. The manager had been in post since November 2019 and completed her registration with CQC on 17 February 2020.

Notice of inspection
This inspection was unannounced.

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

judgements in this report.

During the inspection
We spoke with three people who used the service and five relatives about their experience of the care provided. We spoke with fifteen members of staff including the registered manager and nominated individual. We reviewed a range of records including all eight people's care records, three staff files and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. 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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At the last inspection the provider had failed to ensure risks to people's safety were assessed and mitigated. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found enough improvement had not been made and this breach had not been met.
●Practice at the service placed people at risk of harm. The building was cold throughout the inspection and the hot water in some people's bathrooms was not hot enough to comfortably bathe or shower in. We found one person in bed who was cold, we had to take action to ensure their comfort and well-being.
● The adapted bathroom was not heated. Staff told us people got cold in there whilst they had a bath or shower. One staff member said, "[Name] goes blue on the extremities when we bathe them, we try to do it quickly." This did not ensure people's safety or well-being.
● People were at risk due to a failure to assess the risks of using equipment. Since our last inspection a new bathroom had been installed, however, risks such as people sustaining an injury from equipment, bathing in a room with no heating or people with epilepsy experiencing a seizure whilst bathing were not assessed or managed.
● There were portable electric heaters in use throughout the building, although risks to people's safety had been assessed, the measures required to keep people safe from accidents and injury were not in place.
● One person was given 28 days-notice that they had to leave their placement at Jabulani, they had lived there for a number of years. No clear rationale was given for this decision. The 28-day time frame, which included weekends and bank holidays, did not allow for timely care planning to ensure the safety and welfare during the transition to a new placement for a vulnerable person with complex needs was possible.
● Some staff told us they did not think people were safe. Comments we received included, ""I am worried, Jabulani could be a good place if staff worked as they should." Another staff member said, "I would never put a relative of mine in there, it's awful." This comments was in relation to lack of staff training, poor fire evacuation drills and their frustration over poor infection and prevention control procedures when a person had an infectious illness. The provider did demonstrate they had completed fire drills and infection prevention and control was audited but most of the staff we spoke with told us these were not done effectively.

Learning lessons when things go wrong
● Incidents and near misses were not always investigated. Staff told us they were afraid of, and felt they were discouraged from raising concerns.
● Where people and relatives had raised concerns of inappropriate care or treatment, these were not always

followed up or investigated. Where incidents such as errors in medicine management were identified they were not always followed up to ensure the same thing didn't happen again.

Using medicines safely
At the last inspection the provider had failed to ensure the safe storage, administration and recording of medicines. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found not enough improvement had been made and this breach had not been met.
● People did not always receive their medicines as prescribed.
● Two people were prescribed medicines and the stock of these had run out. One person had not received one of their medicines for four days.

The provider had failed to ensure care and treatment was provided in a safe way. This was a continued breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
At the last inspection the provider had failed to implement effective systems and processes to ensure people were protected from abuse. 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.
At this inspection we found not enough improvement had been made and this breach had not been met.
● People had experienced bullying, neglect and discrimination. We had received extensive feedback from relatives, staff and professionals that the provider used bullying and intimidation against people, relatives and staff.
● One relative said, "[Staff name] has been aggressive and unprofessional towards us." Another relative said, "Staff leave because the owners are vindictive and try to cause problems for people." One staff member said, "[Staff name] taunts a person, bribes them with things they like." Another staff member said, "We feel scared of saying anything or raising concerns, we're frightened of repercussions."
● Action was not always taken to protect people from abuse. We found examples of people telling staff or management they had been verbally or physically abused. These had not always been investigated and had not been referred to the local safeguarding authority. This meant there was no opportunity for an independent professional to investigate concerns and assess people's safety.

The provider had failed to ensure service users were protected from abuse and improper treatment. This was a continued breach of 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.

Staffing and recruitment
● People were not protected from the risk of unsuitable staff as safe recruitment practices were not followed.
● The provider could not prove that criminal records checks had been completed on all staff before they were allowed to work unsupervised with vulnerable people. Other pre-employment checks such as, gaining references, documented evidence of interviews and exploring applicants employment history were not completed consistently.

The provider did not have robust practices to make sure an applicant was of good character and adhere to guidelines set out in Schedule 3 of the Act. This is a breach of Regulation 19 (Fit and Proper Person's Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they did not always have time to spend with people. One staff member said, "People end up waiting for care because there isn't enough staff." Another staff member said, "There's too much to be done, there's no time for care." During the inspection we observed the two staff who were not allocated to deliver the one to one care three people were commissioned for, were task orientated. Their time was taken up with housekeeping tasks rather than offering companionship to people.

Preventing and controlling infection

● People were not always protected from the risk of infection. Staff told us before, during and after the inspection of concerns relating to this matter. The provider had evidenced they had clinical waste collections regularly, however, we saw evidence that normal and clinical waster had been left to pile up on top of bins outside the service. This posed a risk of cross contamination with clinical waster and an infestation of vermin.

● Effective action had not been taken to reduce the risk of a healthcare infection spreading. Staff and some relatives had contacted us before the inspection to advise us there was a problem with the laundry and one person living there had an infectious illness. The registered manager agreed there was a period of time where the laundry was not working, and staff took laundry to a local launderette. We did not see evidence of an action plan or guidance for staff to implement enhanced infection prevention and control procedures. Therefore, not all staff we re supported to fully understand their responsibilities around safe and effective hygiene.

● The home was clean and free from malodours throughout the inspection.

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 Requires Improvement. At this inspection this key question has 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

- Care and support plans did not reflect the most recent evidence-based guidelines or best practice guidance. The registered manager had implemented new care plans that included positive behaviour support. However, these did not adhere to NICE (National Institute for Health and Care Excellence) guidelines as there was no analysis of people's behaviour or guidance for staff to follow if and when people's behaviour escalated.
- People did not achieve effective outcomes from the guidance that was in place. For example, in daily notes some staff had referred to people as being "moody" or "awkward". This showed staff did not understand people's behaviours and did not promote people's dignity.
- There was a lack of understanding from staff and lack of guidance for staff to meet the needs of people with specific health conditions such as dementia or schizophrenia.
- The provider used a listening device in a person's bedroom when they were asleep. The person's care plan stated this was to monitor for signs of a seizure. There was no documented evidence to explain how staff would identify a seizure from the use of the listening device. When asked how they would know if someone was experiencing a seizure from the listening device, one staff member said, "I don't know".
- There was no best interest decision recorded to evidence that the use of a listening device was the least restrictive option. When the listening device was on, staff did not always make sure they could hear it, or that other people or visitors couldn't hear it, this did not respect this person's privacy or dignity.

This provider did not ensure assessments of people's care and treatment needs were effective. This was a continued breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff were not adequately trained, and some did not have the skills or competency required. Staff did not always complete an induction. Some staff who had completed an induction told us this was ineffective. One staff member said, "My induction lasted 6 hours, no-one checked I was doing anything right." Another staff member said, "I didn't have an induction."
- Staff completed on-line training that was deemed mandatory by the provider. Once this was completed there was no system to assess staff competency for anything other than medicine administration. One staff member said, "Training is all on line, we don't really learn anything from it, we need some face to face

training."
● There was not always bespoke training to teach staff how to meet people's individual needs. For example, where people had certain health conditions or autistic spectrum disorder, staff had not received training to meet their needs and preferences. We asked staff about their understanding of certain health conditions people were known to have, one staff member said, "I've never heard of that, is it a health condition? I don't think anyone suffers from that." Another staff member said, "No, I don't know what that is." This meant staff were not empowered to understand people's needs and behaviours.
● One person's care plan guided staff to restrict them from grabbing things off the shelves in shops. There was no guidance to explain to staff how they should do this safely and in the least restrictive way.
● Staff performance was not monitored effectively. Poor performance or evidence of inappropriate care was not always recognised or responded to. For example, one person had alleged that a staff member's communication had upset them. This was not addressed during a supervision or followed up with competency assessments or training. A staff member had made a medicine error and had continued to be responsible for administering medicine without a check on their competency or further training.
● Staff told us that supervisions were completed but they were used as a tool to ask staff to criticise each other and not to offer support or assess their performance. One staff member said, "[Name] was really pushy, kept asking me to say bad things about my colleagues, I felt intimidated and it was bullying." Another staff member said, "[Name] uses bullying tactics and we never get positive feedback from anyone." Some supervisions had been completed by the nominated individual who had no relevant qualifications or experience of working in a care setting. This meant that some staff supervisions were ineffective.

The provider did no ensure staff received appropriate support, training or supervision to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 (Staffing) of the Health and Social Car 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, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection the provider failed to ensure that care and treatment was provided with people's consent and the provider was not working in line with the MCA. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection, enough improvement had been made and the breach had been met. However, further improvements were required to make sure people's rights were respected.
● Mental capacity assessments were now completed, though these were generic, and the same assessments were completed for all people. There was little evidence to demonstrate that people's ability to make decisions was assessed as effectively as they could be.

● The service did not make sure staff fully understood the requirements of consent. The provider did not always assess people's ability to make certain decisions and did not always keep effective records of where decisions had been made in people's best interest.
● People were subject to some restrictions on their liberty, such as staff being instructed to observe people at all times when they spent time with relatives, and not being allowed access to the kitchen or access to food and drink they asked for. There was no evidence to demonstrate that these were the least restrictive option or that these decisions had been made in people's best interest.

Adapting service, design, decoration to meet people's needs
At the last inspection the provider had failed to ensure the premises and equipment used by people were fit for purpose. This was a breach of Regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
At this inspection, enough improvement had been made and the breach had been met. Though further improvement was still required.
● Parts of the home had been decorated since the last inspection, there were more homely touches such as photographs on the walls. Some people's bedrooms were personalised with things they enjoyed and decorated to their taste. A quiet lounge had been made so people had a choice of where to sit or places to go to spend time with family away from other people.
● At our last inspection we found two people shared a bathroom. They only had a bath as the shower that was in there had been removed. Both people were physically mobile so would be able to use a shower if they wanted to. This had not been rectified at this inspection.
● There was limited pictorial signage for people living with disability or sensory loss to understand. Notes and memos on walls were in normal small printed text and were placed at heights that people in wheelchairs would not be able to see.

Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to access healthcare services and support in a timely way. One person had missed two appointments to have their wheelchair checked. They had later sustained an injury from their wheelchair, though it is not clear if attending the appointment could have prevented this. No-one had guidance from a speech and language therapist. This could have helped people's communication needs.

Staff working with other agencies to provide consistent, effective, timely care
● The service was inconsistent in its approach when people moved between services. One person had only been given a short amount of time to find a new placement. We saw the handover to the new service was ineffective and did not include all the information the new service would require to plan and deliver effective care, for example, it did not include significant medical conditions the person had.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to eat a healthy balanced diet because options were limited. Each person had their own menu designed to meet their needs and preferences. However, relatives and staff told us there was not always enough food available. One relative said, "Once I had to go out and buy milk because there was none and there was no petty cash available for staff to buy things, I didn't mind though." Other relatives had contacted us before the inspection to inform us of the lack of food. One staff member said, "Once I looked in the fridge and knew there wasn't enough food for people." After the inspection the operations director told us there was always food in the stock room but on some occasions staff were not aware of this.
● During the inspection we saw there was enough food, but people didn't always have a choice over what they ate and where dietary restrictions were in place, these weren't always recorded to be in people's best

interests. For example, one person had asked to have the same food as other people they were in a car with and been told by staff they couldn't have this. Another person was prevented from consuming alcohol and there was no record of a best interest decision for this.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
At the last inspection the provider had failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
At this inspection, not enough improvement had been made and the breach had not been met.

- People's privacy and dignity were not respected, this included when people were asleep. The downstairs shared bathroom had doors that led directly into two people's bedrooms. One door did not lock and could easily be pushed open allowing access into the person's room.
- There was no noise barrier between the bathroom and people's bedrooms so when a person was in their bedroom they could clearly hear what was happening in the bathroom, this included assistance with people's personal care. One relative said, "It's not fair [Name] has no dignity."
- The bathroom was not big enough to store moving and handling equipment. Staff used another person's bedroom to do this. This meant going in and out of the person's bedroom when they may have been asleep to manoeuvre equipment. This did not respect this person's privacy and dignity.
- People's independence was not promoted. People were not supported to develop their life skills. For example, they could not go into the kitchen unless staff unlocked the door for them. No-one took part in work or education activities. No-one helped with the shopping or household tasks and the provider could not demonstrate that people were working towards their individual goals.

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

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

- The provider did not make independent advocacy available to people. The registered manager showed a lack of understanding about independent advocacy. The provider had an advocacy policy, this stated they would seek to make advocacy available. This had not happened.
- Some relatives told us they were not involved in developing the new care plans. One relative said, "I've never seen the new care plan, I have no idea what is in it, I would have liked to be involved in this." Another relative commented, "The new manager hasn't really been in touch, I want a meeting to sort everything out." A different relative said, "No-one got in touch to discuss the new care plan."

● The registered manager had implemented a "resident meeting" for people who were able to express their views. However, where people had mentioned things they would like to change, no action had been taken. For example, one person said they would like staff to spend less time cleaning. Staff told us they were still under pressure to spend a lot of time cleaning.

The provider did not involve relevant people in decisions relating to the way the regulated activity was carried out. This is a continued breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● Staff were instructed to be task focused and companionship was not promoted. There were enough staff to meet the one to one care that people were commissioned to receive, but other staff who weren't delivering one to one care were busy completing housework tasks or administering medicines. One staff member said, "We have to prioritise cleaning because we are frightened of how [Nominated individual] will react if we don't." Another staff member said, "[Nominated individual] doesn't understand we should spend time with people, he insists we spend all our time cleaning."
● Some staff had worked there a number of years and had formed close bonds with people and their relatives. However, all relatives told us it had been difficult with so many management changes. One relative said, "The turnover of management is hard, different people with different ideas causes problems."
● People and relatives gave positive feedback about the staff. One relative said, "The staff that have been there a long time are top drawer, they are beautiful people." Another relative said, "The staff are always nice."

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 Requires Improvement. 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

At the last inspection the provider had failed to ensure people's care was delivered in a way that was person-centred, appropriate to them and met their individual needs and preferences. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement has been made and the breach has not been met.

● People still did not have choice and control of their own lives. People had restrictions on their freedom that were not assessed and had not been agreed as in their best interest. For example, the kitchen door was keypad locked and people could not go in the kitchen unsupervised. There were no risk assessments that explained this decision. One person was restricted from drinking alcohol with no exploration of least restrictive options.

● Although new care plans had recently been implemented, some contained historic information which was no longer relevant. For example, one care plan stated that if staff called a person by their name it would upset them, however we observed, and staff confirmed this was not the case. The registered manager told us the care plans had to be completed in a short time frame in order to prepare for their next inspection. Unclear and conflicting information in care plans placed people at risk of inconsistent support.

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

● People were not always supported to follow their interests or to take part in activities that were relevant to them. One relative told us, "[Name] is just always in bed, every time I go." Another relative said, "[Name's] muscle mass has reduced because they don't do enough."

● Some people did go out, but relatives expressed concern to us that trips out were not as regular or as long as people would like.

● People's human rights were not always promoted. Visiting restrictions had been put in place on relatives and people who had raised concerns had been told they were no longer allowed to enter the premises. This demonstrated a lack of transparency and understanding of the provider about people's needs to maintain relationships with people that were important to them.

● The provider had brought entertainers into the home and people told us they enjoyed these. However, there was limited evidence of people regularly taking part in activities that would protect them from the risk of social isolation and enable them to forge links within the community.

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

● The service was not meeting the AIS. This was identified at the last inspection and improvements had not been made. People's communication support plans were not person-centred, and the same text was used for everyone. Each care plan stated that people may require pictorial images such as clip-art or cartoons, it was not clear which format people would need their documents to be provided in. One person was visually impaired, their communication needs were not addressed by the generic information in care plans.

● Signs around the home, such as people's menus or a notice about their key worker were printed in standard sized small print and not in formats that people could understand.

The provider did not ensure the care people received always reflected their needs and preferences. This is a continued breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
At the last inspection we recommended the provider reviewed their policies and procedures for handling complaints.

● Complaints were not handled in an open, transparent, objective or timely way. The providers response to complaints did not demonstrate a transparent approach. The complaints policy was not available to people in a format they could understand.

● There were many complaints that had not been responded to, we found one complaint that had not been responded to for two years. There were some complaints that had been responded to but not within the timescale stated in the provider's complaints policy. We found some complaints that had been responded to with incorrect information.

● Some relatives told us they felt they couldn't raise complaints. One relative said, "I've raised concerns with the manager, but she doesn't do anything." The registered manager told us that one person's family complained a lot so now their emails went straight to a spam email box and not all were responded to. This demonstrated a lack of compassionate support when people or relatives raised a complaint.

The provider did not ensure complaints were investigated and proportionate action taken in response to and failures identified. This was a breach of Regulation 16 (receiving and acting on complaints) 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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
At the last inspection the provider had failed to ensure there were effective systems and processes in place to assess, monitor and improve the quality and safety of care. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had not been made and the breach had not been met.

- The provider did not have a clear vision or set of values to guide practice at the service. The service cared for people with a wide range of needs including significant physical disability, complex health needs and complex mental health conditions. This meant it was difficult for staff to fully understand the needs of all the people living there. This was identified during the last inspection and no improvements have been made.
- People told us the service was not well-led. There were low levels of staff satisfaction and the provider did not demonstrate an understanding of the importance of promoting people's human rights. This meant people's needs were frequently overlooked. One relative told us, "The owners are the issue, the staff are great." Another relative said, "I've spoken to the manager about stuff, she is nice, but nothing gets done."
- Staff told us the newly appointed registered manager offered them more support than they had experienced before but they felt the service was still not well-led due to the provider. One staff member said, "Everyone is frightened of [Nominated individual] I do as I'm told and he's rude and intimidating, the same staff get the blame."
- There was not a culture of person centred, high quality care. Staff, relatives and some professionals raised concerns with us about the conduct and manner of the nominated individual. Feedback we received was that the nominated individual used bullying and intimidation against people, staff, relatives and professionals.
- We saw evidence in people's care notes of people being upset at the way the nominated individual had spoken to their relatives. Staff told us they felt frightened of the nominated individual and had at times felt intimidated at work.
- One relative said of the nominated individual, "I don't trust him, and I don't think he's fit and proper to run a care home." Another relative said, "The owners are vindictive and try to cause trouble for people, good managers leave because of the way they are treated." One staff member said, "[Nominated Individual] is a major concern, the way he speaks to residents and staff is frightening."

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems and processes to assess, monitor and improve the quality and safety of services provided were ineffective. The registered manager had designed new governance systems, but these were only introduced in January 2020 and were not operational at the time of the inspection. The governance systems that were in place had failed to identify the issues highlighted in this report.

● At the last inspection conditions were placed on the providers registration. These instructed the provider to send us a monthly report outlining the improvements they had made in relation to risk assessments, accident and incident investigation and governance. At this inspection we found the improvements they had highlighted in the monthly report were not always in place and were not effective.

● The provider had told us they had implemented improvements since the last inspection. These were mainly paperwork based. There had not been a focus on learning or improving care. Staff had not received further training and the lives of people living there had not improved since the last inspection.

● Engagement with people, the public, relatives and the community was minimal. Relatives told us they did not feel involved in the running of the home. The registered manager had implemented resident meetings, but we saw the things people had asked for had not been put in place. The registered manager told us she had tried to arrange a relative meeting, but no-one attended. Relatives we spoke with were not aware this had been arranged.

The provider did not establish or operate effective systems and processes to assess, monitor and improve the safety of the service provided. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others

At the last inspection the provider had failed to submit notifications to CQC appropriately. This was a breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

Enough improvement had been made and the breach had been met, however, further improvements were required to ensure the provider operated in an open and transparent way.

● The provider is legally required to submit notifications to CQC as and when things happen and display their rating and inspection report in the home and on their website. These had now been done.

● The provider failed to operate an open and transparent relationship with people, relatives and relevant professionals. There weren't always investigations after people and relatives made allegations of abuse. Some relatives told us they had not been informed when their relation had had an accident.

● At the last inspection we identified there had been a breakdown in communication with the host local authority. No improvements had been made and this was still the same. The provider did have a more open relationship with another commissioning local authority.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users was not appropriate, did not meet their needs or reflect their preferences.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity or respect

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and Treatment was not provided in a safe way.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Receiving and acting on complaints

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess, monitor and improve the safety and quality of the service were ineffective

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not demonstrate that safe recruitment practices were operated as set out in Schedule 3 of the Health and Social Care Act 2008

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate training, supervision to enable them to carry out their role effectively

The enforcement action we took:

NOP to cancel registration