Leonard Cheshire Disability

Greenhill House - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Greenhill House - Care Home with Nursing Physical Disabilities is a residential care home providing personal and nursing care for up to 38 people whose primary need is physical disability. People had a range of other complex needs including mental health, learning disabilities, autism, acquired brain injuries and degenerative health conditions. At the time of the inspection, 34 people were living at the home across two main buildings and a coach house with four flats. Each person had an individual bedroom with shared bathrooms, lounges, dining areas and kitchenettes.

People's experience of using this service and what we found
People were not experiencing care that was safe or well led. Systems were not in place to effectively manage the home as there had been a period of unstable management. There were insufficient systems to ensure people were supported by enough skilled staff. There was a negative culture within the home and staff were not always recognising poor practice. Audits were incomplete, contained inconsistencies or did not exist.

People spent long periods of time with minimal interaction from staff. Neither did people have care that was personalised to their needs and wishes. Care plans contained contradictions and multiple versions of the same document. People had not always seen health professionals in a timely way. Improvements were found with systems to monitor people's human rights and around medicine management. Representatives of the provider had worked hard at the home to try and stabilise areas such as safeguarding practices even with changes in management at the home. This meant they were being reactive rather than proactive.

Right Support:
People were not living in a home that currently promoted choice, control and independence. Staff lacked time and skills to support many people to go out of the home or participate in meaningful activities in the home. Some people were sitting with minimal interaction from staff for long periods of time. Others with more mobility could choose to move themselves around the home.

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

Right Care:
People's dignity was not always respected due to a negative culture amongst staff as a result of mixed

leadership. Some staff tried their best to have positive interactions with people. However, many would walk through communal areas not acknowledging people. Staff were not challenging poor practice which did not protect people's dignity.

Right Culture:
People were not living inclusive and empowered lives at the home due to an unstable management. There had been three home managers since October 2022 and multiple deputies to support them. Representatives of the provider based at the home had been reactive rather than proactive due to the level of concerns and issues. Systems were only emerging or not in place to manage the home.

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 requires improvement (published 7 December 2022).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. However, we inspected due to further concerns received including from the provider.

At this inspection we found the provider remained in breach of the regulations. Although small improvements had been made in medicine management.

Why we inspected
We undertook a focused inspection to follow up on specific concerns which we had received about medicines management, staffing and safe care and treatment. The provider had raised concerns related to an unstable management prior to this inspection. A decision was made for us to inspect and examine the risks to people. When we inspected, we found there were wider concerns including around person centred care, dignity, staff training and delays to see some health professionals. So, we widened the scope of the inspection to cover all five domains.

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

Enforcement
We have identified breaches in relation to dignity and culture, person centred care, safe care and treatment, staffing, staff training, governance and infection control at this inspection.

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

Follow up
We will meet with the provider following this inspection. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Greenhill House - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors, an inspection manager and a member of the CQC medicines team.

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

Registered Manager
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 not a registered manager in post. There was an interim home manager who started two weeks prior to the inspection. They were being supported by two regional members of the provider basing themselves at the home and two deputy managers.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We were in regular contact with a number of stakeholders including local authorities and regular visiting health professionals to the home. We used the information the provider sent us regularly including action plans. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke or interacted with 10 people and others we observed. We used the principals of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 1 relative and 29 staff including two representatives of the provider, the home manager, nurses, care staff and auxiliary staff. We received feedback from a variety of health and social care professionals during the inspection. We looked at a range documents used to run the service. These included 16 care plans, medicine records, audits, training records, safeguarding, complaints system, rotas and policies.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection, systems in place were not consistently assessing, monitoring and mitigating risks to the health, safety and welfare of people, placing them at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements were found at this inspection. However, not enough had been made at this inspection and the provider was still in breach of regulation 12.

- People's care plans remained disorganised unless they were the small number of plans which had been reviewed. This meant there was a lack of clarity for agency staff and new staff as important information about people was difficult to find.
- Care plans contained multiple versions of the same documents and some documents contained contradictions. For example, 1 person had different health diagnosis on their care plan. Another person did not have a profile completed summarising their needs and how they communicated.
- Care plans for people at risk of seizures often lacked information about how to support them including guidance for staff. Only 6 staff had received recent epilepsy training. When asked, staff were unsure about people's epilepsy.
- People who could place themselves or others at risk when distressed were not supported to reduce the risks. One person who became highly anxious and could hurt themselves was supported by staff who knew no strategies on how to reduce this. There was no written guidance in the person's care plan either. This had resulted in significant harm to the person in the past.
- Blanket monitoring of fluid intake was in place in one of the buildings. The management told us this was an instruction from the GP. However, they had little understanding of why it had been put in place or what the daily fluid target was for each person. Records showed that people's daily fluid intake had not always been totalled. Staff were unsure what target amount of fluid people should be working towards and action they should take if this was not achieved. It was not clear why they were monitoring the person's fluid intake.
- One person with an acquired brain injury was at risk of choking and aspiration because staff were not following guidance in place from a speech and language therapist about thickening drinks. A staff member told us the person was choosing not to follow this guidance. They coughed multiple times when drinking from a can of drink. No staff stopped to check they were safe which was in the risk assessment. The only guidance to not follow the special diet and fluid from the professional was around food and not drink.
- At the last inspection bed rails placed people at risk of entrapment or injury. Improvements had been made to replace bed rail covers to reduce the risk of entrapment. However, on one side of the home, bed rail covers had not all been replaced. One of the provider's representatives told us they had ordered the wrong

ones. By the end of the inspection some had already been changed to the correct ones.
● Action had not been taken to reduce the risks to people in the event of an emergency, such as a fire. A fire risk assessment had been completed on March 2022 and highlighted issues with emergency lighting. This action had not been completed at the time of this inspection. Records did not clearly evidence when fire drills had taken place and fire grab bags did not contain appropriate equipment. Fire grab bags contain essential things in the event of a fire such as blankets, torches and important information. Following the inspection, we contacted the fire service to raise our concerns.
● People were placed at risk of harm because cleaning products were not always being stored safely between use. On the last day of inspection, in a corridor, there was an unsecure plastic carrying box full of chemicals including a neutraliser and cleaning products. Also, a full cleaning trolley with further chemicals such as toilet cleaners in was found unaccompanied. This could place people at risk if they took them. We spoke with a deputy manager who removed them and took them somewhere safe.

Systems continued to not be consistently assessing, monitoring and mitigating risks to the health, safety and welfare of people placing them at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider informed us they had introduced blanket monitoring due to concerns being found in relation to clinical care and documentation. They felt this was a proportionate response to this issue.
● The management had started to thoroughly review risk assessments with people and those important to them. Improvements were found, such as risk assessments for people who chose not to have bed rail covers and 1 person who had been involved in recent safeguarding concerns.
● The management told us they had already ordered new grab bags with essential elements in for the event of a fire.

Preventing and controlling infection
At our last inspection people were not being kept safe from infections spreading. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements were found at this inspection. However, not enough had been made at this inspection and the provider was still in breach of regulation 12.

● People were still being placed at risk of infections spreading including those at high risk due to health conditions.
●Staff did not always use personal protective equipment (PPE) such as gloves and aprons. In many areas of the home staff lacked access to aprons when closely supporting someone with intimate care. On multiple occasions staff were seen walking around with gloves and no aprons when carrying soiled items. One staff member was observed carrying unbagged soiled continence pad with gloves on down a corridor.
● On the first day of inspection, multiple bathrooms were found lacking PPE stock. On arrival of the inspection team one staff member came into the clinical room trying to locate aprons to wear.
● On the first day a bathroom contained two used shower chairs. One was still wet from being used recently. The other was covered in dried on white powder and clearly had not been used recently. This meant there was a risk infection could be spread from person to person from unclean equipment. We handed over our concerns to the provider's representative who took action to address this.
● Cleaning was still not able to fully prevent cross contamination because areas of the home continued to be tired and worn. Scratches and holes were still on the walls and paint was peeling away. Additionally, there was now tape holding broken radiators together. This meant it would be difficult for effective cleaning

to be carried out on these surfaces.

People were still not being kept safe from infections spreading. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During inspection the service manager re-introduced daily walk rounds and they put in place a new system for restocking PPE at night.
● People were able to have visitors, and these were seen throughout the inspection. They could choose where they met in the home.

Staffing and recruitment
At our last inspection systems were not in place to ensure sufficient numbers of suitably competent and skilled staff were deployed at all times. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not being supported by enough suitably skilled and delegated staff. Comments included, "I get fed up and get really, really bored staying here…I have nothing to do. I want to go out to the pub, cinema, ten pin bowling and pantomime", "There is a lot of agency. Not used to it. Prefer old staff" and, "Men agency staff sit on phones." People had to wait for basic care needs to be met such as support with intimate care and there were not enough staff to support people with meaningful occupation and activities.
● Staff echoed what people told us. Some complained about the quality of the agency staff and they were unsure of systems to report this. One staff member said, "A lot of agency [staff] do not know what they are doing." Some staff told us agency staff used their phones and did not engaged with people.
● Staff reported there had been times when people at high risk of pressure ulcers were not able to go to bed to reduce the risks. One person had recently had a pressure ulcer. Staff members felt this was because not enough staff were on evening or night shifts to be able to provide the care the person needed.
● The management were not assessing how may staff they needed based on people's needs. Rotas demonstrated there was a mix of how many agency or permanent staff were on each shift. One day in January 2023 there had been no permanent staff working at the home during the day. This meant there were no members of staff who were able to direct agency staff and knew people well.

Systems were not in place to ensure sufficient numbers of suitably competent and skilled staff were always deployed. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider has centralised systems to support the management to ensure staff had been through a safe recruitment process. The management shared a pipeline of potential new permanent staff they would shortly be interviewing.

Using medicines safely
At our last inspection systems were not in place to manage medicines placing people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements were found at this inspection and the provider was not found in breach of regulation 12 with relation to medicine management.

● Since the last inspection we had been notified from a variety of sources about a series of medicines errors and omissions. Managers were now working to make improvements and improve staff confidence in using the medicines systems safely. However, one deputy manager interrupted a medicine round to ensure a person's dignity was protected without recognising the risks to people of interrupting a medicine round. We informed the provider's representatives who said they would follow this up.
● Staff recorded when people's medicines were administered and creams were applied on an electronic system. However, records showed people's medicines had not always been administered as prescribed. Since the October 2022 inspection medicine errors had been identified by staff at the home, and by visiting healthcare professionals which had led to investigations. No new issues were identified during our inspection, although recent changes to the medicines systems had yet to become embedded.
● Staff, including agency staff, had recently received training on using the electronic system accurately. The agency staff confirmed their shifts were now block booked to try to maintain consistency of staff who were familiar with the systems in use. All staff confirmed they now felt confident in using the system and could make changes in a safe and timely way.
● Medicines prescribed 'when required' had protocols in place to guide staff when these might be needed. However, not all of these were available on the electronic system, and some needed further details from people's care plans. The provider agreed to take action to address this once they were informed about it.
● Medicines were stored securely, including those requiring cold storage. There were suitable systems in place for those requiring extra security. However, temperature monitoring had been intermittent meaning it had not been possible to be assured medicines had been stored at correct temperatures. Recording systems and forms had just been introduced, showing that temperatures will be checked regularly by staff moving forwards.

Systems and processes to safeguard people from the risk of abuse
● Most people were told us they felt safe and happy at the service. Throughout the inspection people were seeking out trusted members of staff to speak with them if they were concerned. One person told us they were happy living at the home. Another person said they loved living here. Some people felt that there were too many agency staff and they were not as happy being supported by these staff.
● There were times that people were left unsupported in areas of the home for long periods of time. People were seen calling out and not responded to on multiple occasions.
● Staff were not always demonstrating their knowledge of how to keep people safe in practice. They knew how to recognise signs of abuse; however, we saw evidence that staff did not always challenge poor practice at the home. Such as intervening when staff were not protecting people's dignity and not questioning inappropriate lack of interactions.
● One of the provider's representative was supporting the management by processing and investigating all safeguarding concerns at the home. They demonstrated openness with the local authority and CQC.

Learning lessons when things go wrong
● Systems were being implemented for learning lessons when things go wrong. Representatives from the provider were completing these in the absence of any stable management team.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to 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

- People were being supported by staff who did not have the skills and had not received an induction, or the appropriate training to be able to meet people's needs. Only 6 out of 59 staff had completed epilepsy or epilepsy awareness training. Similarly, only 5 out of 59 staff had training around pressure care. One staff told us they could not get onto the training site to complete required training. The management informed us staff were given passwords that had expired due to inactivity.
- Staff raised concerns with the inspection team that they had not completed training in how to support people at the end stages of their life's. Records showed only 4 staff had received end of life care training. Since the October 2022 inspection there had been deaths at the service that staff would have supported people through. One staff explained one of the people who had passed away had lived at the home a long time and they felt bereaved.
- Checks to ensure staff were competent in medicine management and moving and handling had not been completed, despite safeguarding concerns being raised in relation to the moving of people and medicine errors being reported.
- Agency staff had not had their competencies checked in any areas whilst working at the service. One deputy manager told us they ask agency staff what competency assessments they have completed during their induction and rely on them providing honest answers. Agency staff were not required to provide any evidence to support their answers. Agency staff profiles indicated some agency staff had completed all their required training in one day. No one in management had questioned this with the agency or staff members.
- In October 2022 inspection, we were told supervisions of staff would be implemented by the management. This had not occurred. Staff raised concerns about the lack of support they had received.

Systems were still not in place to ensure sufficient numbers of suitably competent and skilled staff were deployed at all times. This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed our concerns in relation to agency staffs competency assessments with a representative of the provider. They took action to address the concern.

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

- Systems were not in place to assess people's support needs in a timely manner when they moved in, or their needs changed. One person had moved to the service over a year ago and some of their care records had not been completed until January 2023. Other people had not had care plans reviewed or updated since 2019 or 2020. This meant that there was a risk people may not have their needs or wishes met

consistently.
● People with learning disabilities and autistic people were not having their care assessed or delivered considering the guidance 'Right support, right care, right culture'.
●Staff had not received training in line with statutory requirements. One person was Deaf and little had still been put in place to meet the British Sign Language Act 2022. Staff had not completed any training in relation to sign language and staff did not attempt to sign with the person when interacting.

Supporting people to eat and drink enough to maintain a balanced diet
● People had been involved in discussions about changing the menu at the home. However, mealtime experiences were functional and were not personalised. For example, when people required support to eat, staff did not speak with them or eat with them to model social meals.
● People were unable to choose when they ate their meals and what they had. Some people were seen having their breakfast around 11:00 or 11:30am and their lunch was at 12:30pm. Staff did not check whether people were ready to eat their lunch or consider that two meals were being provided in close proximity to each other.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always accessing other health and social care professionals in a timely manner to meet their needs. Many people had not had any oral health care for years despite their care plan saying it should be every six months in some cases. Following the inspection, the provider stated this was part of the national issue in dental provision.
● Some people told us they could see a doctor when they felt ill. Others had records they had recently seen a variety of health professionals. This included speech and language therapists, dieticians, opticians in the past and specialists for their health conditions.
● People were supported by physiotherapists who worked at the home part time. They had created detailed action plans for how people should be positioned in bed and the types of exercises staff should do with people daily.

Adapting service, design, decoration to meet people's needs
● People were able to personalise their bedrooms how they liked. One person liked graffiti and had that on their walls. Another person told us their bedroom had just been painted and they chose the colour. Other people had photos, pictures and objects that were important to them in their bedrooms.
● However, the home was in a generally poor state of decoration. There was paint peeling off the walls. Skirting boards and door frames were coming away from the wall. In one office there was a ripped floor where some cabinets were moved. We were told there was a 'maintenance work schedule' although this was never shared with us.
●Bedrooms were often too small for the specialist equipment people had and the wheelchairs they used. For example, one person knocked their biscuit tin off a chest of drawers when turning their wheelchair around to speak with us in their bedroom. Some wheelchairs were being stored in corridors so were not accessible to people.

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.

● People were not always having their capacity considered in line with current legislation. One person's capacity assessment and best interest decisions were not completed until over a year after they moved to the home. The capacity assessment did not show all methods of communication including the person's first language were explored.
● Another person at risk of choking and aspiration had assumed capacity, however access to their cans of drinks were restricted as they were stored in a manager's office. There was no evidence a speech and language therapist had been involved in this decision or the person had consented to the storage of the drinks.
● Staff knowledge around capacity and consent was mixed. Some staff recognised capacity should be assumed. Others were less clear on when capacity assessments and best interest should be applied.
● These shortfalls remained an area for improvement. The management were now working hard to ensure people's capacity and best interest were considered around specific decisions. Improvements were starting to be seen and we were informed further training for staff will be explored.
● Systems were now in place to manage DoLS at the home. The management had a clear system in place to identify when authorised DoLS required reapplying. They had been chasing unauthorised DoLS with local authorities and making sure any conditions were met.

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 our last inspection we rated this key question good. At this inspection the rating has changed to 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

- People were not always treated and supported with dignity and respect. Many staff interactions were task based rather than caring. Examples were witnessed where people's dignity was not considered. One person's body was exposed whilst being wheeled through a corridor. Another person was supported with their meal by a member of staff who did not interact with them. Frequently, large napkins were used to wipe their face between mouthfuls.
- In one of the buildings people were treated with little dignity or respect by staff. All people had blue plastic aprons at mealtimes put on them by staff without checking it was what they wanted or needed. No consideration had been made about the impact on their dignity and whether it was their choice.
- People were left with minimal interaction for hours once they had been helped up from bed and moved to a living space. Some people were sat in front of a television whilst others just went to sleep. Many staff walked through main communal area without acknowledging or greeting people. On occasions staff were talking over people or calling across the room to each other with no thought to the person they were supporting.
- People were not always receiving support in a timely manner to protect their dignity. One person was calling out "help" repeatedly from their bedroom for over 6 minutes. Eventually they stopped because no one came. There was a strong smell of urine outside their bedroom. The inspection team informed a senior member of staff about this because no staff were aware or responded to the person's calls.
- Another person was witnessed calling out for 10 minutes before being responded to by a member of staff. A third person requested to go to the toilet before lunch and staff did not assist them to the toilet immediately after lunch.
- Language being used by staff to refer to people and their needs demonstrated little respect and not conducive to person-centred care. Staff were heard saying things like "feeding", "toileting" and "who is left to get up." No people were involved in these conversations and considering them as adults with rights.

People were not treated with dignity and respect by staff. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A few staff were working hard to interact in a kind and caring way with people. They were demonstrating treating people with dignity and respect. The management had put in place a new handover since the last inspection to ensure important information about people was shared including changes.

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

● People were not always involved in decisions about their care because their preferred methods of communication were not used. One person was seen getting upset and it took a familiar member of staff to provide assurance and understand why. This person's usual communication system was broken and the agency staff member was unsure what they wanted.

● People were unable to choose when and where they ate. Meals were served at set times and served in the dining area. Only when people had been out did the options change. People who required specialist support in relation to their nutrition because they had a feeding tube were not included in the dining experience. They remained in a separate room when meals were served.

● Other people were able to vocalise or indicate their choices well. Although these were limited to what was going on around the home. Mainly the same people accessed the community regularly.

● People were able to choose where they went in the home if they were able and assessed as safe to do so. Some people chose to spend time outside of their living units whilst others moved between communal spaces and their bedrooms. However, there were minimal systems in place for those less able to communicate to promote independence skills.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs; 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

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 who had different ways of communicating did not have personalised systems in place. Care plans had not been written in an accessible format for people who relied on easy read documents with pictures to support text. Staff had not received training to be able to communicate in line with people's needs. Systems had not been put in place to support a person who had English as a second language. No interpreters had been sought for people who required them.
- People's care and support plans were not always up to date and in line with their current wishes and needs. This meant new and agency staff would not have up to date information to refer to placing people at risk of receiving support that did not meet their needs. Daily notes were not reflective of people and how they spent their time.
- Two people did not have a one-page profile for agency staff to familiarise themselves with people when they started. Other people's profiles missed key pieces of information required to meet someone's personal needs and wishes. For example, one person who had specific mobility needs had nothing about this in their profile. Another person who was meant to be monitored regularly by staff had no information about this in their profile.
- People's care plans contained contradictory information which meant staff did not have accurate information to be able to care for people. One person had a diagnosis in one part of their care plan which was different in another part. Other people's care plans had multiple versions of documents so could confuse staff as to which is the version to follow.
- People were not receiving care that was individualised to their interests and wishes. Many people were placed in in front of televisions by staff. People had no way to change the channels or programmes that were put on. Neither did they have the mobility to independently move away to do something else.
- Activities in the home were limited to those being run by a designated member of staff. Often, they were not meaningful for many of the people living at the home. People were often limited to how much they could participate and had no way to communicate whether they wanted to be involved. One person told us

they were not very happy and "Get bored quite a lot." Another person told us about something they would like to do. Nothing had been explored for them around this potential hobby.
● Games were seen piled up in one part of the building in a communal space. Many would be unable to be accessed by people using wheelchairs. Those that could be accessed were disorganised and were not seen being used by the people.
● Some people rarely went out of the home. The management referred to some of the people as being too "frail" to leave the building. No options had been explored to identify other stimulating activities could be provided.
People were not receiving care that met their needs, reflected their preferences and enabled them to make decisions. This is a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new management shared work that was ongoing to review each person's care plan with them and those important to them to ensure they reflected their current needs. They explained this was going to take some time as they wanted to do it thoroughly.

End of life care and support
● People were having their end of life needs and wishes considered. There was a mixture of how these were recorded in people's care plan.

Improving care quality in response to complaints or concerns
● People were seen going to staff of their preference to raise concerns. One person went to the same member of staff to raise concerns. They informed us they trusted the staff member and preferred to speak with them. However, another person felt some staff were not open to helping them.
● The provider had systems to manage formal complaints. One of the provider's representatives talked us through how they had recently been managing a complaint. They were aware it had fallen out of the current time frame keeping the complainant informed to ensure the process was followed.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection systems were not in place to ensure people were treated with dignity and respect by staff due to a poor culture of accountability. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were found at this inspection with some members of staff. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

- Systems were still not in place to ensure a culture of accountability was in place. Staff still had a culture of not taking action or raising concerns when poor practice was witnessed by the inspection team. For example, staff walking through areas of the building and not acknowledging people or inappropriately supporting a person with their meal.
- Interactions were often functional with little thought behind them about the person. Some people were having lunch less than an hour after receiving breakfast. Oversight systems had not identified this issue. It was seen happening again on the last day of inspection despite it being raised by the inspection team on the first day.
- Staff were still assembling in small groups around the home rather than prioritising people. Examples were seen in both main buildings communal spaces. One new member of management had to break up a group of staff they recognised as gathering to talk rather than support people . No other staff questioned this behaviour.

People were at risk of poor care because systems were not embedded to ensure there was a person-centred, open, inclusive and empowering culture. This is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A few staff were trying to improve the culture of accountability in the service. Senior managers were trying to lead by examples. There were also care staff who greeted people when they walked through communal spaces.
- A representative of the provider informed us of recent examples where staff had spoken out and raised concerns with them. They explained they were starting to witness a culture shift although it was slow.

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

● People were not being supported in a service that had a consistent management or effective systems to keep them safe and deliver high quality care. Since the October 2022 inspection there had been three service managers and multiple deputy managers.

● Currently, there was reliance on management from other services to come and support the home. The provider had arranged for two regional managers to be based at the home. This did not demonstrate a sustainable system to ensure quality and compliance in this home.

● Minimal improvement had been made since the last inspection in October 2022. There were the same breaches in regulation and new shortfalls were found.

● The management had been predominantly reactive rather than proactive with reliance on external bodies. For example, the competency of agency staff and the lack of training around specific clinical tasks and equipment was only addressed once this had been highlighted to them. Systems were not established internally to ensure all messages from health and social care professionals were communicated to management.

● Systems were not in place to ensure people were safe and receiving quality care. Audits were either being developed, not in place or failed to identify the concerns found at this inspection.

● Systems were not in place to check the competency of both staff and agency staff until during the inspection.

● Systems were still not in place to accurately determine the right level of staffing for the home based on people's needs. Neither were systems in place, apart from a morning handover, to manage each shift in the home. The impact of this was seen throughout the inspection, such as people sitting around with no interactions for hours, call bells sounding for long times and people having little time between two meals.

● The provider and management were not ensuring current evidence-based guidance, legislation and standards were being followed. For example, 'Right support, right care, right culture', statutory learning disability training and the Autism Act 2009 for people with learning disabilities and autistic people were not being followed. Best practice for epilepsy care plans was not followed for all people being supported with epilepsy.

● Inconsistencies were found in documents that had been developed to oversee the service at manager and provider level. Examples such as the clinical risk register was not reflecting people accurately. The risk register created by the provider since the last inspection to share with other agencies did not match this and some findings either.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and staff were positive about changes they had noticed in the last two weeks. Comments included, "New manager I like", "New manager is very polite and responsive" and, "It is improving. I feel confident with the new manager." The provider had alerted the local authority and regulator in January 2023 about ongoing concerns they had at the home.

● The provider's regional manager's working at the home had been working hard to keep people safe. However, due to an unstable management at the home, they had been reactive rather than proactive.

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

● Systems were in place to ensure the provider was following the duty of candour. Throughout the process senior management had demonstrated openness with people, their relatives and external stakeholders

about the situation the home was currently in.

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

● People were not as involved in their care as they should be and the provider's representative acknowledged not everyone had a key worker to support this process. Also there had been an unstable management at the home for over six months. The new management were starting to rectify this. Recently, they had involved people in redesigning the menus.

● Staff felt they had not had the opportunity recently to contribute to the running of the home. On the last day of inspection there was a staff meeting and it was clear they were starting to be involved by the new manager.

Working in partnership with others

● Systems were in place to work with a range of health and social care professionals. Physiotherapists were regularly working in the home to help support people's mobility. There were weekly visits from the GP to monitor people's complex health conditions. However, due to the COVID-19 pandemic and unstable management connections with some health professionals appeared to have been lost. For example, few people had recently had their oral health managed.