Achieve Together Limited

Woodbridge House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodbridge House is a residential care home providing personal care to nine people with learning disabilities and autistic people at the time of the inspection. The service can support up to 10 people in one adapted building.

People's experience of using this service and what we found
There was a lack of effective risk management in the home to ensure people's safety, especially in relation to people at risk of constipation and choking. There was a lack of risk management, training and support strategies for staff to support people when they expressed emotional distress.

Medicines were not always managed safely and there was a lack of protocols to provide guidance to staff for the use of 'as required' medicines. Incidents were not always recorded and effectively reviewed. Lessons were not always learnt to prevent an incident reoccurrence and reduce risk.

There were systems in place to protect people from abuse but not all staff showed a good understanding of safeguarding practices. There were enough staff in the service to meet people's needs. Infection prevention and control was managed safely.

There was detailed assessment and planning of some care needs people have, such as epilepsy, but this was lacking in other areas, such as behaviour support planning. Staff completed an induction and training programme and received supervision, although feedback around the frequency of this was mixed. Staff worked with other agencies to ensure people's healthcare needs were met.

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. Best interest decisions were not completed effectively.

People's care was not always planned in a person-centred way as there were gaps in care planning for some needs. Staff knew people well and knew their likes and dislikes. Care plans contained information about people's preferences.

People's communication needs were known but these were not always consistently applied in practice. For example, the lack of use of picture menus. People were not always proactively supported to do activities they enjoyed and supported effectively to maintain contact with their relatives. People and relatives could raise any concerns they had but these were not always acted on. Where known people's wishes around their end of life care were recorded.

The provider had not ensured effective management of the service. Quality checks and audits had not identified the concerns we found at inspection. People were at risk of poor outcomes from a lack of safe and

effective person-centred care. The provider had not notified CQC of all significant events. The provider engaged with people, relatives and staff to seek feedback on the service, but this had not always been effective. The provider had failed to tell us about an incident which involved the police, which they are required to do by law.

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

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

Right support:
• The Model of care and setting did not maximise people's choice, control and independence. The home was registered to support a maximum of 10 people. This is larger than the current best practise guidance. The provider had not been able to reduce the impact of this to people as people did not choose who they lived with, and not everyone in the service got on well together, there were some incompatibilities.
Right care:
• Care promoted people's dignity, privacy and human rights but was not always person-centred. Staff encouraged people to make their own choices and maintain their independence. However, people did not always receive care and support that met their needs and was not therefore always person-centred.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people lead confident, inclusive and empowered lives. Feedback from relatives was not always acted on and people and relatives were not always involved with their care planning.

People received support from a caring staff team who promoted their independence and respected their privacy and dignity. People's equality and diversity needs were assessed.

Following the inspection, the registered manager has taken action in relation to feedback from a relative.

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

Rating at last inspection
This service was registered with us on 21 September 2020 and this is the first inspection. The last rating for the service under the previous provider was Good, published on 28 March 2020.

Why we inspected
This was a planned inspection due to the length of time the home has not being inspected since the change of provider. The service had been under the new provider since September 2020.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

Since the inspection, the provider has taken action to mitigate the risks to people around constipation, choking and management of expressions of emotional distress.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in Safe in relation to the management of risk and the safe management of medicines, in Responsive, for the failure to act on a complaint; and in Well-led the lack of management oversight of these issues and the failure to maintain accurate and complete records for each person.

Please see the action we have told the provider to take at the end of this report.

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 report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Woodbridge House

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Woodbridge House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We met people who lived in the home and spoke with three relatives about their experience of the care provided. People we met were unable to communicate their views to us. We observed staff interactions with people throughout the day. We spoke with five members of staff including the registered manager, deputy manager, a team leader, senior support worker and support worker.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. 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 looked at training data and quality assurance records. We received feedback from one commissioner and one health and social care professional who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this service under a new provider. This key question has been rated as Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● There was a lack of effective risk management in the home. On arrival at the inspection we found the front door to be ajar despite a keycode lock in use. This put people at risk of harm. Everyone living at the home required constant supervision and care and at least two people were at known risk of leaving the home without support.

● Risks to people were not assessed and mitigated safely. People at known risk from constipation did not have the guidance staff needed to ensure their safety. One person's care records showed they had not had their bowels opened for one week and it was not clear what action had been taken other than as required medicines on two dates. There was no guidance for staff in any of their care records when they would need to give 'as required' medicines. Three staff gave us different responses as to when to administer this medicine and records had not been checked by staff to see if they needed this medicine. This was despite records showing signs they were distressed at the time which was a sign they may be constipated.

● Risks of people choking were not managed safely and staff gave different accounts what they would do if a person choked. There had been an incident where one person had choked on a piece of food they were given. One staff told us they would not give this food to the person as the person swallows without chewing. Guidance given by the Speech and Language Therapy team had not been added to the person's risk assessment. For example, staff were not aware to use a separate plate and give one piece of food at a time to avoid the person overloading their mouth.

● Risks related to people's expressions of their emotional distress were not managed in line with positive behaviour support best practice guidance and the provider's own policy. One person had moved to the home in June 2021, with one to one support due to their needs when they were agitated. There were known risks of a serious assault on staff, of throwing items, of barging, hitting and grabbing others' bodies and hair but these had not been assessed and mitigated. The person's behaviour support plan was inadequate as it did not include all the known risk behaviours and provide any strategies for staff to use if their behaviour escalated to a physical assault. The plan had not been reviewed since July or following incidents.

● There was a lack of effective guidance for staff on how to support this person when they are expressing their distress. Recommendations made to support the person when showing signs of distress had not been included in their care plans and had not be put into practice following incidents that had occurred. This put the person, staff and other people at risk of harm. The plan did not include the use of 'as required' medicine to guide staff when this should be used. There was a protocol in place for this which stated to give the person 'as required medicine for agitation', however staff we spoke with described a different response.

● Not all environmental risks were managed. Staff confirmed that people would go into the office and there was a hammer on the side in reach which posed a risk. One person's behaviour support plan stated they would touch hot objects in the kitchen if their agitation escalated, but there was no mention in their plan how to manage this. There was a broken bath panel protruding from the bath with sharp edges which posed

a risk of injury to people.

The provider had failed to do all that is reasonably practicable to assess and mitigate risks to the health and safety of people. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during and after the inspection. We asked them to complete or review risk assessments for everyone at risk of choking in the home. However, the assessment for one person remained unsafe, referred to the use of a de-choker device which are not recommended by the Resuscitation Council UK; and did not offer any guidance for staff what to do if the person loses consciousness. We sought further reassurance from the provider by a further review of this risk. We also asked for a positive behaviour support plan to be written for this person to include the known risks and strategies to keep people and staff safe.

The registered manager responded immediately to the environmental risks we raised. They called maintenance to assess the bath panel and put the bathroom out of action until repairs could be completed.

● Risks to people around fire safety were safely mitigated with all the expected safety checks and assessments completed. People had personal emergency evacuation plans in place, these were to ensure people could leave the building safely in the event of an emergency. All the required safety inspections had been completed to ensure the environment was safe such as gas and electrical safety, equipment servicing and legionella testing. Health, safety and fire audits were completed monthly and identified any actions needed.

Using medicines safely

● Medicines were not always managed safely and in line with the National Institute for Health and Care Excellence (NICE) best practice guidelines for medicines in care homes. NICE is the independent organisation responsible for driving improvement and excellence in the health and social care system.

● 'As required' medicines such as those prescribed for constipation did not always have any guidelines for staff how these should be used. This presented a risk staff would not give people these medicines safely and in line with their needs. For example, when they should be given and when to seek further medical attention if they don't work effectively. One person was prescribed medicines for constipation but did not have any Medicine Administration Records (MARs) for these. We spoke to the registered manager about this who said the person no longer uses these medicines. Medicines no longer used should have been reviewed with the person's GP, recorded as discontinued and any stocks returned to the pharmacy.

● Another person had been given an 'as required' medicine for constipation, but there was no protocol or care plan, no MAR entry as a prescribed medication, and it was not on their medication profile. It had just been written on the reverse of their MAR.

● Eye drops which were prescribed for one person on 23 August 2021 and should be used within one month of opening remained in the fridge. Another person's eye drops were stored with their other medicines, were also past one month of opening and had no information whether they should be stored in a fridge or not. Short course medicines and other medicines no longer used should be returned to the pharmacy and whilst there were systems in place for this, they were not always followed.

● Medicines checks were ineffective as although these were completed weekly and manager's audits monthly, they had not identified the concerns we found and were not kept up to date. For example, there were no audits for one person who had lived at the home since June 2021. These audits had not identified that one of the medicines was prescribed and in stock, but not included in the person's care plan or recorded anywhere.

The provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during and after the inspection. They have implemented PRN protocols for people using as required medicines for constipation.

Learning lessons when things go wrong

● The provider had a system for reviewing incidents and accidents, but this was not always effective. Incidents were not always recorded. For example, daily records showed one person had grabbed staff in October 2021, but no incident record had been completed. It was not always clear what action had been taken as a result of each accident or incident. For example, there was no recorded management action for one incident when a person had thrown plates, grabbed staff and tried to pull staff hair. Lessons had not always been learnt to prevent a reoccurrence, identify trends and mitigate risks.

Systems and processes to safeguard people from the risk of abuse

● Systems and policies were in place to protect people from abuse and avoidable harm. The registered manager understood their role and had reported concerns to the local safeguarding authority and CQC.

● Staff had received safeguarding training. However, one of the staff we spoke with did not demonstrate a clear understanding about safeguarding issues and the need to report to the local safeguarding authorities any allegation of abuse.

● Relatives we spoke with thought their loved ones felt safe living in the home.

Staffing and recruitment

● Enough staff were deployed to keep people safe and meet their needs. The manager checked people's commissioned hours against staffing ratios to identify the staff hours needed in the home and kept these under review. We observed people's needs were met immediately. Relatives we spoke with told us they thought there was enough staff.

● Management checked staff competencies in key areas such as medicines and infection prevention and control to ensure they have the skills and knowledge to fulfil their role.

● Staff were recruited safely. All the required pre employment checks were completed. For example, employment history, references and Disclosure and Barring Service (DBS) background checks for all staff. These checks help employers to make safer recruitment decisions.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections. Staff had been vaccinated as a condition of their deployment, unless medically exempt.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

This is the first inspection for this service under a new provider. This key question has been rated as Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs and choices were assessed prior to moving into the service to ensure staff could meet people's needs and keep them safe. This was carried out in-line with the Equality Act 2010. This ensured people's protected characteristic, such as disability and religion were positively promoted. However, there was a lack of effective assessment for behaviour support planning in the home. Despite known risks of people expressing their distress through physical aggression, there were no physical intervention strategies for staff to use to keep themselves and others safe. Physical intervention strategies include non-restrictive strategies, such as breakaway techniques to help staff to keep safe from harm.
- There was detailed assessment and planning of people's other care needs for example, supporting people with epilepsy and their personal care. The registered manager and staff were able to tell us about people's needs, but had not always known how to keep people safe.

Staff support: induction, training, skills and experience

- There was a training programme in place for staff which included training identified as specific to people's needs such as epilepsy and autism. However, this did not include positive behaviour support training at the level required in the service. Staff confirmed this, one staff said, "I did Passport training first part… physical intervention is part 2 and I have not done that. Sometimes you need it if people are 'going off'." The language used by staff here also suggests a lack of understanding of the reasons people express their emotional distress.
- The registered manager monitored staff compliance with training and ensured staff were booked on training they needed to complete. Where they had been unable to complete face to face learning during Covid-19, staff had completed eLearning instead.
- Staff, including bank staff, received an induction to the home and supervision. There was mixed feedback from staff on how often supervision was held. One staff told us they had this about six-weekly, where as another staff told us they had two in the last year. Staff files suggested staff did not have regular supervision but when we spoke to the registered manager about this, they were able to evidence some supervisions which had not been filed.

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

- The staff team worked with Speech and Language Therapists (SLT) to ensure people's needs around eating and drinking were fully assessed, and care plans were kept up to date to support people to eat safely. For example, people had thickened drinks and pureed meals. However, there were concerns with the risk management of choking in the home.

● People were supported to eat and drink enough. Where required people had fluid charts in place to monitor the amount they had drank. Although the provider had forms with people's recommended daily allowances for fluids, these were not being competed by staff to show how much fluid people needed to aim to consume. No-one living in the home was at risk of weight loss.
● People were not consistently given a clear choice of what meals they ate. The menu in the kitchen was from the previous week. The picture menu board was not complete and had not been updated. It did not have any pictures for dinner and lunch was only a picture of pureed food which didn't match what people ate. On the day of the inspection people were having sandwiches or soup for lunch. People were not really given a choice as when we asked what people were having for lunch staff said, "It is sandwiches or soup [for people on modified diets]."

Adapting service, design, decoration to meet people's needs
● The home had been adapted to meet people's needs. People who used wheelchairs had bedrooms on the ground floor.
● There were different areas for people to spend their time with two lounges and a dining room; and a garden for people to spend time outside.
● People's bedrooms were personalised to their likes and interests.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to maintain their health and received annual health checks with their GP. Records were kept of all people's health appointments such as visiting the dentist and opticians.
● Staff worked with other agencies to ensure people had effective care such as SLT and Occupational Therapists.

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.

● Mental Capacity Assessments were completed for people where required, for example for decisions around their medicines, community access with support, personal care, nutrition/hydration, medical appointments and treatments, and finances. These clearly evidenced people did not have capacity to make these specific decisions. However, they consistently did not record what decision was made in people's best interest and how they had reached this decision. There was a clear lack of understanding by the staff who had completed these.
● Some people had conditions as part of their authorised DoLS. For one person this was to monitor risk and the need for DoLS and to inform if their Relevant Person's Paid Representative (RPPR) does not have monthly contact. Everyone who is deprived of their liberty under the Mental Capacity Act must have a representative. This could be a family member or a friend but if there is no one suitable it could be a Paid

Representative also known as a RPPR. There were no reviews or records if this condition was being met and the contact details for people's RPPR were out of date as this had changed nearly a year ago. However, the RPPR confirmed they had monthly contact.

● One person had documents in their care records signed by their relative. Relatives can only consent on behalf of their loved ones if they have a Lasting Power of Attorney (LPA). This is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. The registered manager was unable to provide any evidence this relative had a LPA. This can be checked with the office of the public guardian.

● Restrictive practices plans and checklists were completed for people. These helped to ensure the use of any restrictive practices such as locked doors were clearly identified and appropriate to the risks to the person.

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.

This is the first inspection for this service under a new provider. This key question has been rated as Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were not involved in planning their care. Different staff told us that people's care plans were written by the registered manager and the deputy manager. We asked staff if there was a way to involve people and were told that staff would observe people and then tell the registered manager and deputy. There was no planned approach for actively involving people in their care planning.
- People chose how they spent their time. For example, some people liked to have their own space in their bedroom, some people liked to relax in the main lounge and one person liked to spend time in the smaller lounge. One person liked to spend time in the kitchen, helping staff prepare lunch.
- Staff we spoke with said, "I try and treat them all the same and make sure their needs are met. If I feel they are not getting met, I will speak up and ask why not. Especially if I see nails not getting cut, I ask why. They can't speak for themselves, so I try and speak for them."

Respecting and promoting people's privacy, dignity and independence

- Some language used by staff was not respectful. Some staff used inappropriate terms when discussing people experiencing distress. During our site visit we heard staff speaking loudly about people using the toilet. This was not respectful of people.
- People's privacy and dignity were promoted. Care records were held securely, and people respected people's dignity when providing personal care.
- Staff promoted people's independence where possible. One staff said, "People can pick out their clothes, make their own beds, go to the shop and pick items they want to buy. One person loves to go to the farm shop and give money over and he will stand and wait for the change. If it's a family members birthday coming up, we take people to the shop to choose a card. People choose what film they want to see."

Ensuring people are well treated and supported; respecting equality and diversity

- We observed a calm environment in the home. In the lounge the TV was on with music playing, staff were spending time with people and there were gentle and caring interactions and light-hearted humour. Relatives we spoke with described the atmosphere in the home as warm and friendly.
- Relatives we spoke with thought their loved ones were happy living at the home. Comments included, "We can tell when we see (name), they are content." And, "I think it is good for (name), they are happy and happy to go back when they visit." Surveys completed by the provider with people and their relatives showed positive responses about the care people received.
- People's equality and diversity needs were considered. Pre-admission assessments included equality and diversity which fed through to people's care plans. For example, their religion and sexual orientation.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this service under a new provider. This key question has been rated as Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

● There was a clear provider complaints policy and procedure which was available and promoted in the home. There had not been any complaints in the home since January 2021. People were asked if they had any concerns during annual surveys. Relatives told us they could raise any concerns they had, and relative surveys completed by the provider said the same.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care was not always planned in a person-centred way. For example, one autistic person's care plan contained no information about their sensory needs. This had been left blank with a note to review since they had moved there in June 2021. Staff told us they may offer toys but there was no planned and assessed approach to providing sensory input. Other people had detailed information in their care plans about their likes and dislikes, daily routines and how they like to spend their time. This gave staff the information they needed to support people in line with their wishes.

● Staff told us the manager and deputy manager wrote people's care plans. Relatives told us their loved one's care plans were not discussed with them. One relative told us that reviews were not regular for their loved one. Another relative said, "I only know what's going on if I phone them." There was a lack of involvement of people and their loved ones, which impacted on a person-centred approach.

● The home was not in line with the principles of Right support, right care, right culture as people had not had real choice in who they live with, and there was evidence of people's incompatibility. For example, we were told one person would shout at another person 'to shut up'; and another person did not like being in the presence of one of the people they lived with and this would lead to incidents. Staff told us they would move one of the people away, but there was no guidance on what to do if the person didn't want to move away, or how to stop the issue from occurring in the first place.

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

● There was a lack of a proactive approach to supporting people to do the activities they enjoy. People had daily activity planners, but for one person there were identical suggestions for each day and their records showed they often went to bed and didn't participate in the activities they enjoyed. People had not returned to getting out and about for activities they enjoyed doing since lockdown during Covid-19, such as swimming, college and bike riding. Relatives told us they would like to see their loved ones doing more activities.

● On the day of our inspection there were some activities happening in the lounge with a singing and dancing activity, and some people were sat being encouraged to join in by the lady running the session. The

registered manager told us the lady visited twice a week. We asked staff about the activities one person liked and they told us they liked to be stroked and to listen to soft music. They did not mention any of the activities identified in their activity plan.

● People were not always supported well to maintain contact with their loved ones. One relative told us their loved one was often not able to visit as there were not always drivers available to take them. Whilst there had been difficulties with contact during Covid-19, the provider could have been more proactive to support people to see and maintain contact with their close relatives and to avoid social isolation. People's loved one's birthdays were known so staff could support people to send them a card and present.

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.

● People had care plans which clearly identified their communication needs and staff we spoke with could tell you how people communicated their needs. Other documents evidenced the use of picture cards to support people's understanding of information. Pictures were used to make information more accessible in care records and in the home, but this was not always consistent. For example, the lack of a picture menu on the day we inspected.

End of life care and support

● No-one was currently receiving end of life care. Where possible, information was recorded about people's wishes for their end of life care. For example, we saw one person had an end of life plan they had been involved with completing.

Requires Improvement

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.

This is the first inspection for this service under a new provider. This key question has been rated as Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Governance systems in place had not ensured high quality and safe care. There were failures in risk management and learning from incidents. Audits were not effective in identifying shortfalls in risk assessment and care planning such as in relation to risks to people from constipation, choking, managing the expression of emotional distress and medicines management. Incidents had not been effectively and consistently recorded and reviewed to support continuous learning.
- Care records were not consistently up to date and complete. Some records were from the previous provider and some records were from a person's previous home. For example, one person's, 'Keeping safe in my home' care plan was for a previous home.
- One relative we spoke with raised some concerns with us regarding the lack of communication they have about their loved one. We raised this with the registered manager who took immediate action and has arranged for weekly communications. However, the same relative had raised this in a previous survey, this had been analysed and noted in October 2021 but had been recorded as low priority and no action had been taken to improve this identified concern.

The provider had failed to assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate and complete records for each person. The provider had failed to improve the quality of the service. This is a breach of regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had failed to meet their regulatory requirements. Providers are required to notify CQC about certain events and incidents. There had been an incident where a person had been injured, which the provider would be required to notify CQC about and they had failed to do so.

Statutory Notifications had not been sent to CQC. The failure to notify CQC of significant incidents is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

- The registered manager was in the home two days a week as they had been supporting another of the provider's home for three days a week. The other days were supported by the deputy manager. The registered manager accessed various networks and information from other agencies to keep up to date with the latest information.
- Audits were completed to identify other concerns and actions needed in the service, for example for Infection prevention and control and food safety.
- It is a legal requirement that the latest CQC inspection rating is clearly displayed at the service where a

rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgment. A copy of the previous provider's inspection report was on clear display in the service.

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

● Whilst people were being supported by caring staff, there was a not always a person-centred culture as there were gaps in some people's care planning. For example, in relation to constipation, choking and the management of people's expressions of their emotional distress. This places people at risk of poor outcomes from a lack of safe and effective person-centred care.

● The registered manager understood the duty of candour as, 'Our responsibility to report, taking ownership of improvements and lessons learnt and sharing with others including family.' People's loved ones were informed of any incidents and the registered manager was able to give examples of this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager sought feedback from people and their relatives. A suggestion box was available but had not been used. Surveys were completed with people and their loved ones to obtain feedback on the service. These were reviewed and included any actions needed such as someone wanted their room repainted. However, these actions had not always been completed. For example, relatives' surveys showed communication with relatives needed to be improved. Feedback we had from relatives also supported this.

● People had regular meetings with staff where they could raise any concerns or ideas. Staff used this as an opportunity to ensure people were aware of how to report abuse and how to make a complaint. Group activities, health and safety and maintenance issues were also discussed, for example the importance of washing your hands properly for good infection prevention and control during Covid-19.

● Meetings were held with staff to provide any updates and opportunity for feedback. However, from reviewing a meeting held in October 2021, the meeting mostly consisted of reminders to staff of what they need to do, rather than opportunity for dialogue. Staff told us the registered manager was, "As supportive as they can be…and if you need time off, they're pretty good."

● People were involved with their local communities and attended local facilities such as college and various clubs although this had dwindled due to Covid-19.

● The manager promoted peoples' and staff equality and diversity. Equality and diversity considerations were included in people's needs assessments.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of a significant event.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that is reasonably practicable to assess and mitigate risks to the health and safety of people. The provider had failed to ensure the proper and safe management 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. Regulation 12(1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate and complete records for each person. The provider had failed to improve the quality

of the service.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 17(1)(2)(a)(b)(c)(e)