Lester Hall Apartments Limited

Lester Hall Apartments

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Lester Hall Apartments is a residential care home providing accommodation and personal care for people living with mental health needs, including those living with dementia, physical disability and/or Autism. Accommodation is in one adapted building over three floors with a passenger lift. The service is registered for up to 33 people and there were 21 people living in the service at the time of inspection.

People's experience of using this service and what we found
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.

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

Right Support; care and support were not personalised, routines were not consistently followed and opportunities for social inclusion was limited.

Right Care; staff did not provide consistent care that was dignified and respectful.

Right Culture; not all staff had the required skills or competency to provide safe and effective care.

Risks associated with people's care and support needs were not sufficiently assessed, monitored or mitigated. This placed people living at the service at increased risk of harm.

Safeguarding procedures had not always protected people from experiencing harm or abuse. People told us they did not always feel safe living at the service.

Staff deployment did not consider staff skill mix and competency. There was a high use of agency staff who were not sufficiently trained or experienced to meet all people's care and support needs. Staff recruitment was ongoing. The management team took action to make some immediate improvements.

The providers policies and procedures reflected best practice guidance and recognised assessment tools were used. However, incident management policies and procedures were not consistently followed, and this impacted on learning and opportunities to mitigate further risks.

New and improved audits and checks had been implemented. Action plans were in place to support the service to improve. Further time was required however for improvements to be embedded and sustained.

People told us they were not happy with the quality and choice of meals. The provider had completed a recent mealtime experience review and agreed to complete this again.

Staff's approach to care and support was inconsistent. Some staff showed dignity, respect, encouraged independence and opportunities to participate in activities, others did not.

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.

People had been supported with their health conditions and accessed external health care services. Recommendations made by external health care professionals were implemented.

People and visitors had access to the provider's complaint procedure. An ongoing refurbishment plan was in place to improve the decoration and furnishings. A new sensory/quite room was being developed.

Medicines management followed expected best practice guidance. People received their prescribed medicines when required.

Improvements to infection prevention and control practice had been made. This included an increase in domestic staff and more robust cleaning.

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

Rating at last inspection and update
The last rating for the service was requires improvement (published 4 November 2021) and there was a continued breach in regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections. However, the current provider has managed the service since 2021. At this inspection enough improvement had not been made/sustained, and the provider was still in breach of regulation and new breaches were identified.

Why we inspected
The inspection was prompted in part due to concerns received about the staff deployment and competency of staff to meet people's individual needs. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the all sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The provider took some immediate actions to mitigate the most urgent risks and this has been effective.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lester

Hall Apartments on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, how people were protected from avoidable harm, how people received person centred care, staff deployment and support and the governance of the service. See the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Lester Hall Apartments

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lester Hall Apartments is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Lester Hall Apartments is a care home with without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of the inspection the registered manager was not working.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service. We sought feedback from the local

authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (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 with four people who use the service and six relatives to ask about their experience of the care provided.
We spoke to the deputy manager, two under managers, the provider's quality and compliance manager, head of service and ten staff. This included the cook, agency care staff, a senior care staff, support workers and bank support workers.

We looked at five care files along with a range of medicine administration records. We looked at other records relating to the management of the service, including four staff recruitment records, complaints, staff deployment, staff training and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included further training data, quality assurance records 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; Learning lessons when things go wrong

- Risks had not been adequately assessed, monitored or mitigated. For example, one person's pre-assessment record showed risks to their safety increased, when experiencing periods of heightened emotional need. Details and guidance for staff on how to manage and mitigate all known risks were not available. This increased the risk of unnecessary harm.
- Staff were not all sufficiently competent, skilled or experienced in meeting people's individual care and support needs. Staff told us they were struggling to meet the needs of everyone living at the service and they had "lost confidence" and did not feel "competent" and were "fearful." The provider had failed to ensure people received safe care and support from skilled and competent staff. This put people at risk of harm.
- Staff were trained in positive behavioural support and Management of Actual and Potential Aggression (MAPA). One person's incident records showed they had experienced frequent episodes of high anxiety that resulted in physical intervention. We were concerned about the type of physical intervention used, for example floor holds with up to five staff. Incident records showed a lack of staff consistency, positive engagement with the person and routines not being followed. All of which were in the person's positive behavioural support plan for their safety. This increased the risk of harm.
- The providers policies and procedures in relation to 'physical intervention' and 'behaviours that challenge' were not consistently followed. For example, following an incident, debrief meetings and a specific record detailing the physical intervention used, were required to be completed. This was not routinely happening. This shows the provider had failed to ensure all actions had been taken to learn from incidents and mitigate further risks.

The provider had failed to ensure known risks had been sufficiently assessed, monitored and mitigated. Staff were not sufficiently skilled and competent to meet people's individual needs safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took some immediate actions to mitigate risks. This included reviewing a person's risk assessment, arranging additional training and increased the management oversight of risks.

- Health and safety audits and checks were completed regularly. This included fire safety, equipment and water monitoring in relation to the risk of legionella. Personal Emergency Evacuation Plans were in place and up to date.

Systems and processes to safeguard people from the risk of abuse

- Three people did not consistently feel safe. One person described there being at times a "fearful, violent

atmosphere." Another person said, "I'm not happy here. I don't feel safe anymore. I'm worried about being assaulted by others who live here."
● We were concerned about the diverse needs of people living at the service and the safety risks posed to some people. Staff shared concerns about their ability to safely support people from abuse and avoidable harm due to the complex needs of some people living at the service. This put people at increased risk of harm.
● From reviewing one person's incident records, we were concerned of the frequency and type of physical intervention used and was concerned this may have been disproportionate. Due to a lack of staff's confidence in meeting this person's needs, since May 2022 the person spent the majority of time in their bedroom. We were concerned this was a restriction on their liberty and movement.

The provider had failed to ensure people were sufficiently protected from abuse and avoidable harm. This is a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the concerns raised by people with the management team who agreed to follow this up. They also told us of their actions and plans to review the service, including a consideration of compatibility of those living at the service.
● We were aware safeguarding incidents and concerns had been reported to the local authority, police and the Care Quality Commission (CQC) when required. Prior to the inspection we were aware of two safeguarding incidents involving two staff. Staff disciplinary action had been taken in response to unsafe or abusive practice by staff.

Staffing and recruitment
● People and relatives raised concerns about staff deployment. A relative said, "There's no consistency of staff. There's a massive turnover. Every time I arrive there's different staff there. I don't know any of them, except for the senior staff." A person said, "There's not enough staff, a lot have left or are scared of a resident."
● Staffing was inconsistent. Agency staff were heavily relied upon due to recruitment difficulties. Whilst in the main, regular agency staff were used, this still impacted on people receiving consistent care. For example, some people required two staff over a 24 hour period and this was provided by agency staff which could be different every day.
● Agency staff had not completed training in all relevant care, support and safety needs required to safely support people. This compromised people's safety. For example, they had not received training in ligature risks and management.
● Staff employed at the service told us they had received training in mental health needs but did not feel this was sufficiently detailed or was provided in a way that supported their leaning and development.

The provider had failed to ensure people received consistent care and support from staff who were suitably trained, skilled, experienced and supported. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team told us they had recently made some changes to the training programme. This needed further time to become fully embedded. We were also told a 'One Page Profile' document had been introduced, to support all staff to have easy access to important information.
● The provider had safe staff recruitment procedures. This included, Disclosure and Barring Service (DBS) checks, this provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

At the last two inspections, we found the provider had failed to comply with infection control measures in relation to Covid-19, and staff use of PPE (Personal Protective Equipment). This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of Regulation 12.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 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.

Visiting in care homes
● People were supported to maintain contact with their family, friends, and advocates. The provider had safe visiting procedures in place.

Using medicines safely
● People received prescribed medicines safely. People told us they received their medicines when required. A relative said, "[Relation] used to lose their temper when they were woken up in the morning to take their tablets. The psychiatrist got involved and they have sorted it out."
● Medicine ordering, storage and returns followed best practice guidance. Medicines had been reviewed by the GP or specialist. Examples were given by the senior support worker of people's medicines having been reduced.
● Staff responsible for administering medicines, received ongoing training and competency assessments. The provider had a medicines policy to support staff practice.
● Medicines management procedures included regular monitoring and checks. Records confirmed action had been taken when shortfalls were identified.

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.

Assessing people's needs and choices, delivering care in line with standards, guidance, and the law
- The provider's pre-assessment process was not robust. Emergency placements had been made for people with complex care and support needs. Two people's pre-assessments showed a lack of assessment and planning to ensure staff had the required skills and experience. There was also a lack of planning to ensure the environment met people's needs and safety. This placed people at risk of not receiving safe and effective care.
- The provider's policies and procedures reflected best practice guidance but were not consistently followed by staff. Please see the safe section of this support for details. This impacted on people receiving safe effective care and support.

The provider had failed to ensure known risks had been sufficiently assessed, monitored and mitigated. That staff were sufficiently skilled and competent to meet people's individual needs. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- People were not consistently supported by staff who were sufficiently trained, experienced or skilled. Permanent staff raised some concerns about the quality of training due to it being delivered online. This meant the opportunity to ask questions was not there.
- Agency staff were heavily relied upon and were used daily. From reviewing agency staff profiles and speaking with agency staff, we found not all had the level of experience and skills required to provide safe and effective care. This exposed people to unnecessary risk of harm.
- Staff did not consistently receive opportunities to discuss their work, training and support needs. Two staff reported they received regular supervision meetings. However, three staff reported they had not received a supervision meeting despite being employed between four and five months.

The provider had failed to ensure people received consistent care and support from staff who were suitably trained, skilled, experienced and supported. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- Negative feedback was received from people about the choice and quality of meals. A relative said, "This is a big problem, [relation] is a big eater and if they don't like the food it can be a trigger." A person said, "The

food is rubbish."
● The management team told us they had completed a dining experience review and would repeat this to follow up on the concerns raised.
● People's dietary needs had been assessed and planned for. Staff had access to people's dietary needs. The cook was knowledgeable about people's individual needs, preferences including cultural diets. However, dietary records found in the kitchen were not up to date. We raised this with the management team who agreed to review the information available for kitchen staff.
● Food stocks, storage and management were found to meet best practice guidance. The service had a five star rating with the food standards agency, meaning they were compliant with expected practice.

Staff working with other agencies to provide consistent, effective, timely care
● Systems and processes were in place to share information with external professionals such as ambulance, hospital accident and emergency departments and police in the ongoing care of a person. This meant people had access to more joined up care.
● The staff were supported by community nurses, a GP who attended a remote weekly meeting to review and discuss health related issues and concerns. Care records also confirmed information was shared with health and social care professionals involved in people's care.

Adapting service, design, decoration to meet people's needs
● The environment did not always meet people's needs. Some concerns were raised by people and relatives about the suitability of some bedrooms in meeting people's physical needs. We shared this with the management team who agreed to follow this up. The management team gave an example of a person who was in the process of moving bedrooms to allow for extra space and easier access.
● At the time of the inspection, the provider was continuing with a refurbishment plan. This included, replacing flooring, decoration, new furnishings and the development of a sensory / quiet room.
● People had access to a pleasant secure garden area with a smoking shelter and seating, a BBQ and a small selection of outdoor games equipment were available.

Supporting people to live healthier lives, access healthcare services and support
● Feedback about meeting health care needs was positive. A relative said, "Its better now the different professionals are talking to each other." Another relative said, "Staff are helpful. [Relation] had to go to hospital for the first time, and for a few days staff were sent to sit with them for several hours, which I thought was very good."
● The management team gave examples how some people could refuse to attend healthcare appointments and treatment. They advised how they tried to encourage people and shared this information with external professionals involved in people's care.
● From reviewing care records and speaking with staff, people were supported to access health services. This including attending the dentist and optician, and specialists such as psychiatry services.

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.

- DoLS applications were appropriately submitted to the local authority. We reviewed an authorisation with conditions and found this was being met.
- We saw examples of capacity assessments and how best interest decisions had been completed with the involvement of relatives, advocates or representatives.

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.

Respecting and promoting people's privacy, dignity, and independence

- Staff were not always caring. We received a mixed response about people's experience of the staff's approach. A relative said, "I would say [staff] are caring individuals." Whilst another relative said, "[Relation] is pushed into the lounge where they sit all day. They need to be hoisted into a chair, but they seem to be lacking a hoist." We checked the hoist was working and regularly serviced and found no concerns. We shared this feedback with the management team who agreed to follow these concerns up.
- People did not receive consistent care and support that was respectful and dignified. During the first day of our inspection, we observed some staff in the garden smoking and using their mobile phone in the company of people they were supporting. We raised this with the management team who told us this behaviour was not in line with the providers policies and procedures. We were concerned of the risk this posed to people due to staff not being able to respond to people's needs quickly.
- People's independence was not always encouraged. Some staff gave examples of how they promoted independence. A staff member said, "I encourage people to assist with changing their bed linen, prompt them to wash themselves, clean their teeth." Another staff member gave an example of how a person was able to use the self-service at the shop and the positive impact this had upon them. Staff also told us they felt some staff, lacked motivation to encourage and promote independence. This showed a lack of consistency by staff.

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

- People did not receive consistent individualised care. We saw some positive staff engagement with people that showed they knew people's individual needs, routines and what was important to them. This included sitting and chatting with people, However, we also saw a lack of staff engagement with people. For example, staff did not always have positive and meaningful interaction, other than when they were supporting with a care task such as offering a meal or drink.
- The assessment process considered people's protected characteristics and staff had received training in equality and diversity. People's diverse and cultural and religious needs were discussed with them and recorded in their support plan. We saw examples of how people's religious and cultural needs were being met. This included meeting cultural dietary needs and plans were in place to support a person to attend a place of religious worship.

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

- People were not consistently involved in decision making. There was a lack of evidence of how people were involved in making decisions about their care and support. The management told us people were

encouraged to review their support plans with staff when they were reviewed monthly. However, engagement with people was not always recorded. We were therefore not assured people consistently received opportunities to be involved in making decisions about their care and support.

● Some people had a paid advocate to support them. However, information about independent advocacy services had not been made available to people. An advocate supports a person to express their views and wishes, and helps people to stand up for their rights.

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.

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

- Staff did not follow people's support plans. A person's positive behavioural support plan provided clear guidance on how staff should support them with their preferred routines. However, staff were not responsive and failed to consistently follow the guidance. This detrimentally impacted upon the person's wellbeing as care was not person centred and led to the person becoming distressed which compromised everyone's safety.
- Assessments for people admitted in an emergency, did not include detailed information about their care and support needs. This meant staff did not know how to provide support in a way that empowered people to have choice and control.
- People did not receive consistent person centred care. High dependency on agency staff meant people were not supported by consistent staff who knew them well. People were not supported to receive care that met their individual needs, preferences or routines. This meant people were exposed to the risk of care not being delivered in their best interests.
- Activities were not always available. A person said, "It's boring, I get tired of staying in all the time." A relative said, "[Relation] needs to get out more, a walk, a bit of exercise and basic stuff like that." However, we observed during our inspection people were supported with activities of their choice. This included, visiting the local library, going shopping and walks in the community.
- People were at risk of socially isolated. People were reliant on staff to support them to engage in social and community activities and opportunities. We found this did not happen consistently and staff failed to positively engage people.

The provider had failed to ensure people received care and support based on their individual needs, preferences and routines. This was a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care records confirmed how the provider had responded to a person's increased needs. This included seeking support and guidance from external health and social care professionals.
- Due to concerns identified during the inspection about staff deployment and the impact on inconsistent care people experienced. The provider took immediate action, this included improvements to staff deployment and management oversight.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were assessed and support plans were developed to inform staff of these needs. We saw examples of staff working with speech and language therapists in meeting people's different and preferred communication needs. For example, communication cards were used to support a person to express their needs.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure. The complaints log confirmed actions had been taken to investigate concerns and make improvements where required.

● People felt able to raise concerns. The complaints procedure was available in easy read for people. A relative said, "The seniors are very receptive, I've never felt the need to escalate things."

End of life care and support

● At the time of the inspection, no person was receiving end of life care. However, end of life care wishes had been discussed with people and recorded. This meant staff had information about how to care and support people at the end stages of their life.

● If a person had a do not attempt cardiopulmonary resuscitation (DNACPR) or Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents. This information was recorded. These documents informed staff of people's wishes or decisions made should emergency care be required.

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.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people

At the last inspection, the provider had failed to ensure systems and processes were robust to demonstrate the service was effectively managed. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvements had been made, but further time was required for new and improved systems and processes to be fully embedded and improvements sustained.

- Systems were not fully embedded to assess people's care needs and risks. The care records for two people with complex and diverse needs lacked a robust assessment and effective oversight, which increased the risk of harm to their health, safety and well-being.
- The provider's policies and procedures in relation to behavioural management, had not been consistently followed. Incident management recording, monitoring and analysis was not robust. This impacted on the opportunity for learning and mitigating further risks. The provider failed to ensure people were not exposed to the risk of unnecessary harm.
- There was a lack of consistent leadership and effective monitoring. The management team did not attend the staff handover to monitor the quality of communication and information shared.
- Systems to monitor staffing was not effective. The senior support worker on duty was responsible for allocating duties but this was not monitored by the management team to check staff worked effectively. For instance, we saw staff were disorganised and people not clear what staff were allocated to support which people. This increased the risk of having a negative impact on people's emotional needs.
- The system to monitor staff deployment was not effectively monitored to ensure people received consistent care from qualified, skilled and competent staff. Given the complex and diverse needs of people using the service and the high use of agency staff; we were not sufficiently assured the provider had continuously reviewed the staff skill mix and support needs.
- The staff team did not work together as a team with some staff, lacking commitment and purpose in supporting people to achieve positive outcomes.
- The system to screen agency staff was not consistently followed. For instance, when an agency staff member arrived for work, they were asked to leave because there was no profile found to confirm who this

staff member was. The agency worker told us they had worked at the service on the previous day and the staff rota confirmed this. We shared our findings with the management team.
● There was a lack of transparency and management oversight with regards to record keeping. For instance, staff recruitment processes did not always have a record of the interview responses used to determine the applicant was suitable for the position. Staff probationary meetings were not always recorded, and we could not be assured these were being completed in line with the recruitment procedures.

The provider had failed to consistently assess, monitor and mitigate risks and to maintain accurate records. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had identified improvements were needed and was using a consultant to support them to make the required changes. Areas where we found improvements made were with the environment, infection prevention and control practice and improved senior management support to the service. Monthly audits and checks had been completed and actions plans were in place to drive forward the required improvements. This included shortfalls identified during this inspection.
● Staff recruitment was ongoing and new positions developed to strengthen the management and support at the service. In March 2022 a voluntary suspension on new placements was implemented by the provider. This was due to the unstable staff team and concerns about how emergency placements had been accepted.

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
● The management team demonstrated an open and transparent approach and understood their responsibilities around the duty of candour.
● They management team were open and honest about the shortfalls we identified during the inspection in the fundamental care standards we expect all providers to meet. They had sought support from external health and social professionals, recognising they required additional support.
● Relatives told us they were informed of any incidents that occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● High staff turnover and agency staffing were people's and relative's greatest concern. Concerns also related to meeting people's complex needs safely and effectively. Some relatives reported they did not know who the management team was but spoke positively about the senior support workers.
● People and their relatives received opportunities to share their experience of the service. A 'you said, we did' poster dated August 2021 provided feedback to people of the actions taken as a result of what had been shared. However, people could not recall being asked for their feedback. We shared this with the management team who advised the annual quality assurance survey was due again in August 2022.
● Weekly resident meetings gave people the opportunity to raise any issues, concerns. Meeting records also showed community trips were also discussed and planned.
● Staff spoken with told us they enjoyed working at the service, but they felt concerned about the diverse and level of complex needs people had. They did not feel consistently listened to or supported. A staff member said, "I enjoy my work but it's frustrating and harder to make a difference to people's lives." Another staff member said, "Staff meetings give us a chance to say what we think. I'm not sure if anything will change."

Working in partnership with others

● Staff worked with external health and social care professionals. Records confirmed how staff sought support from external professionals and implemented any recommendations made.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received care and support based on their individual care and support needs, routines and preferences. Regulation 9 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from the risk of abuse and avoidable harm. Regulation 13 (1)

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 fully embed and sustain improvements and to complete robust actions to assess and mitigate risks and complete accurate records. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The provider had failed to ensure staff were deployed sufficiently to meet people's care and support needs and that they had the required skills, experience and competency to meet people's individual needs.

Regulation 18 (1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed had to sufficiently assess mitigate known risks. Regulation 12 (1) (2)

The enforcement action we took:

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