Achieve Together Limited

Sheringham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sheringham House is a residential care home providing a regulated activity of personal care for up to 10 people. The service provides support to people with a learning disability and autistic people. At the time of our inspection there were 9 people using the service. The service was a large home and people's rooms were on the ground floor and first floor.

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.

Right Support: People were not always supported by staff to pursue their interests or supported to achieve their aspirations and goals. We looked at one care plan which contained no detail about what the person wanted to achieve in their life. Staff did not support people to take part in activities and pursue their interests in their local area and to interact online with people who had shared interests. People did not take part in meaningful activities; this was in part due to the staffing numbers. One relative told us, "They [staff] always say they need more drivers to take people out, they do so little for [person]." Staff members told us people were not going out enough.

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.

Right Care: The service did not have enough appropriately skilled staff to meet people's needs and keep them safe. People were not always getting their one-to-one support hours and we observed on more than one occasion people being left alone without their one-to-one staff member. People who had individual ways of communicating, using body language, sounds and pictures cards were not always supported by staff to do so. We did not see staff using picture cards to interact with people whose care plan outlined this was a method they liked to use. People's care and support plans did not reflect their range of needs and this did not promote their wellbeing and enjoyment of life. One relative told us, "[person] hadn't been out for nearly a month."

Right Culture: People did not consistently receive good quality care and support. We observed staff supporting a person in an unsafe way, which could cause injury. Our observations were shared with a senior manager. Staff had received manual handling training however some staff were using poor practice without questioning it or raising it as an issue. Staff turnover was high, which did not support people to receive consistent care from staff who knew them well. One relative told us, "[person] needs someone to take

[person] out, they always say there is no drivers."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was inadequate (published 04 March 2022)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 05 September 2022. Breaches of legal requirements were found.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sheringham House on our website at www.cqc.org.uk.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels, providing safe care and the management of the service at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Sheringham 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Sheringham House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Sheringham House is a care home 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 our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 05 September 2022 and ended on 08 September 2022. We visited the location's service on 05 and 07 September 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 this information to plan our inspection.

During the inspection
We spoke with two relatives about their experience of the care provided to their loved ones. We spoke with eight members of staff including the regional manager, the home manager and six care staff. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at 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.

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 inadequate. At this inspection the rating for this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At the last inspection the provider failed to always manage risks associated with people's care in a safe way. We identified concerns relating to managing health needs, the physical environment and staff COVID-19 testing. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- The provider had failed to ensure people's individual health risks and risks from the environment had been fully assessed and mitigated. The service did not consistently keep people safe through formal and informal sharing of risks and management strategies.
- People who lived with epilepsy did not always have a detailed plan in place for staff to follow. We spoke to a staff member regarding a person who wore a protective helmet to reduce the risks from falling during a seizure. During inspection we noticed the person was not wearing their helmet. The staff member told us they were informed by the manager that the person didn't need to wear it. However, when another member of staff came in, we heard them being informed by the deputy manager that the person should be wearing their helmet. There was no guidance or reference to a protective helmet in the person's care and support plan. Not all staff knew when the person needed to wear it and they were at risk of injury if they had a seizure and fell and hit their head.
- People who had dysphagia were at an increased risk of choking as there was not enough guidance in place for staff. Dysphagia is a medical term used for people who have swallowing difficulties. Some people's care plans identified what level (consistency) of food they needed according to their SALT (Speech and language therapy) assessment, however there was no guidance on what types of food were suitable for people's individual levels. IDDSI guidance details foods such as sausages and peas are unsuitable to be pureed. During the inspection and other occasions, as identified in the daily care notes, these types of food were pureed for people with dysphagia, increasing their risk of choking.
- People who were at risk of becoming underweight were not supported by staff to follow their SALT assessment guidance. Some people's SALT guidelines detailed they needed fortified food to aid with weight gain. Fortified food includes full fat creams, milks and yoghurts that can be added to food to increase calorific value. There was no additional food available in the cupboard or fridge to ensure food could be fortified. When we asked the staff member who was preparing the lunch on the day of inspection, they were unsure what fortified food meant and confirmed this had not been happening.
- Staff had failed to ensure they consistently supported people in line with safe moving and handling guidelines. We observed two staff members supporting someone in an unsafe move called a 'drag lift'. A

drag lift is a widely recognised unsafe manual handling manoeuvre where staff pull someone up from under their arms. This move can cause pain and injury to the person and staff members.
● The environment was not always safe for people. The registered manager had not ensured areas of the garden were tidy and free from risks to people. There were a number of bins in the garden that had an open top containing used gloves and masks, which posed risk of spreading infection. There were people in the home who displayed PICA behaviours and were at risk of going through bins and attempting to eat items. PICA is an eating disorder where the person would eat inedible items. There was a large area of stinging nettles in the garden and a broken flowerpot in the sand pit that people used. People who lived there had free access to garden and we observed people accessing the garden. Following the inspection, the provider informed us they had addressed immediate the safety issues and were committed to carrying out improvement works in the garden to ensure people's safety.
● Staff did not consistently follow risk assessments relating to managing soiled linen. The risk assessment outlined that linen should not touch the floor or any other surface. We observed washing being pulled from the washing machine and dragged across the floor increasing the risk of clothes becoming contaminated.
● We asked the provider to urgently address the environmental risks, the guidance for people's food who had dysphagia, the lack of fortifying foods available, epilepsy guidance and the unsafe manual handling manoeuvre.

The provider failed to manage risks associated with people's care in a safe way. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were elements of the management of risk that were safe. People had personal emergency evacuation plans (PEEPs) in place which detailed how to support the person to leave the service if there was an emergency.
● 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.

Visiting
On arrival to the service the provider checked visitors were not displaying any symptoms of COVID19

Staffing and recruitment
At the last inspection the provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Health and Social Care services are experiences significant workforce pressures widely across the sector, however the provider had not taken appropriate action to mitigate the impact of this on service users following the findings at the last inspection.
● The service did not have enough staff. People were not receiving consistent one-to-one support to take part in activities and go out when they wanted. We observed on more than one occasion, one person not being supported by their 1-1 member of staff. The home manager told us that six people needed 1-1 support but there was not always enough staff to support their 1-1 hours. One staff member told us, "If we had more staff they (people) could go out more. Also having to do the cooking and cleaning impacts on how much

time we have to spend with people."
● The home manager told us five staff were needed to support people with their care needs in the morning and then a further four staff in the afternoon. The service did not always have this number of staff to support people. For example, during July 2022, the rota highlights one day there was three staff at the beginning of the shift in the morning who were then joined by another three members of staff throughout the rest of the day.
● The numbers and skills of staff did not match the needs of people using the service. One person needed the support of two staff members when leaving the home. The rota did not allow for this 2-1 staffing and therefore the person did not leave the home as often as they wanted. The daily notes for this person detailed, on more than one occasion, that they had requested to go out but had been unable to due to staff shortages.

The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
At the last inspection the provider failed to ensure accidents and incidents were monitored, recorded and reported. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The home manager did not have a robust system in place to have oversight of incidents or accidents. There was no analysis in place to pick up any trends or patterns. The service was in the process of moving from paper-based incident reporting to computer based but this was yet to be embedded.
● Staff were not always able to determine what was an incident, accident or behaviour . There had been no incidents or accidents recorded online or in the folder since the middle of July 2022. The home manager told us some things might be recorded on behaviour forms. There were incidents of physical aggression on the behaviour forms that had not been reported using the providers incident reporting policy. The home manager told us staff needed further learning to identify what qualifies as an incident or accident. When incidents and accidents are not recorded in line with the provider system, the home manager is unable to have a clear analysis and oversight.

The provider failed to ensure accidents and incidents were monitored. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems and processes were not robust to ensure people were always protected from the risk of abuse. Safeguarding records did not always highlight what action had been taken when concerns were raised. For example, there was an incident where a person had self-harmed and the home manager was unable to confirm if this had been reported to the safeguarding team. Other incident forms did not always detail whether safeguarding or CQC had been informed.
● One person's monthly key worker review detailed they had three incidents reported to safeguarding during that month. It did not outline what these incidents were and when we asked the home manager to see the incident reports there was only one incident recorded.

● Although safeguarding systems of recording were not robust, One staff member told us what would constitute as abuse and another staff member told us, "If there was any abuse, I would tell the home manager straight away."

Using medicines safely
At the last inspection the provider failed to ensure the management of medicines was always undertaken in a safe way. 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 has been made at this inspection and the provider was no longer in breach of this part of regulation 12

● At the last inspection we found concerns relating to MAR (medication administration record) charts not being completed and dates not being written on medicines that had expiration periods as stated by the manufacturer. At this inspection we found MAR charts were being completed and open dates being displayed on items such as creams.
● However, staff did not always follow systems to record and store medicines safely. On one occasion when a person left the service for a social visit to family it was not recorded what medicines left the home and what came back. Staff could not be sure the number of medicines they received back were correct. After this was brought to the attention of senior management who addressed this with the staff team to ensure lessons were learnt from this incident.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (Stopping over medication of people with a learning disability, autism or both) and ensured peoples medicines were reviewed by prescribers in line with these principles.
● A staff member who was trained to administer medicines was able to describe people's preferences. For example, how one person liked staff to put the tablets in their hand for them to take them.

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 requires improvement. At this inspection the rating has remained the same. 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
At the last inspection the provider failed to ensure care was designed to meet people's needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this part of regulation 9.

- At the last inspection people did not have regular reviews with their key worker. At this inspection the same concerns were identified.
- Peoples care and support plans did not consistently set out strategies to promote independence and consider the long-term aspirations for the person.
- People had monthly key worker review folders. One person's monthly key worker folder had not been completed at all since March 2022. Prior to March the key worker folder contained an overview of information such as what appointments and activities they attended that month. The level of detailed varied from person to person and we could not sure what activities the person did or wanted to do.
- People's care and support plans did not contain information about goals and aspirations. People's care and support plans referred the reader to the key worker folder to read details about goals they may have set. The key worker folders did not contain information regarding people's goals, aspirations or skills. One relative told us, "Staff do not seem to have the initiative to do stuff with people."

The provider failed to ensure care was designed to meet people's needs and preferences. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection risks associated with people's health needs were not always being met. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this part of regulation 12.

● At the last inspection people did not have access to routine healthcare appointments . At this inspection, people had attended healthcare appointments, but action had not consistently been taken to address health concerns. For example, one person's follow up appointment notes detailed they had been to the opticians who found they had cataracts in both eyes. We asked the home manager what action has been taken but they were unaware they had cataracts and told us they would follow this up with the persons GP.
● There was a delay in accessing healthcare appointments. For example, one person needed to see their GP after a recommendation from the SALT team. This appointment was not made until four weeks after the recommendation.
● One person had been offered hydrotherapy sessions by an external healthcare service. The home manager was not able to tell us if the person had attended their hydrotherapy as planned or not. The record keeping was insufficient to allow the manager to ensure this happened. The person was offered the sessions to help with their physical health

Risks associated with people's health needs were not always being met. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff ensured people were able to access urgent appointments and emergency services when needed. During our inspection, 999 was called to support someone in the service and staff acted promptly when someone presented as looking unwell. Staff spoke to the GP and the persons medicine was altered.

Staff support: induction, training, skills and experience
At the last inspection the provider had failed to ensure that staff received appropriate training and supervision this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At the last inspection supervisions were not carried out regularly and training was not always effective and up to date. At this inspection the same concerns were identified.
● People were not consistently supported by staff who had received relevant and good quality training in evidence-based practices. For example, more than one person at the service had been identified as having PICA. PICA is an eating disorder of non-food items. Only one staff member had training to understand PICA. People who had been identified as having PICA were at risk of not receiving appropriate support for their specific health need.
● Staff had completed safe moving and handling training. However, this had not been effective as we observed staff not following safe moving and handling guidelines when supporting a person.
● The number of supervisions carried out with staff had increased from the last inspection. However, there remained a number of staff that had not a supervision meeting with their manager. The communication book and staff supervision notes highlighted that staff attendance at training was low. One staff member told us, "There was a big drive for us to do the online training, but we have to do it in our own time, on our day off." Supervisions give staff and chance to highlight any issues they have but also to ask for support and opportunities to expand their learning and knowledge in their role.

The provider had failed to ensure that staff received appropriate training and supervision. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed an induction before they started their role , however the induction did not provide staff with training such as PICA prior to supporting people . One staff member told us, "We were introduced to people and their needs, we also have a fire safety induction."

Supporting people to eat and drink enough to maintain a balanced diet
● People did not consistently receive support to eat and drink enough to maintain a balanced diet. Staff told us the food shop did not contain enough nutritious food for people. For example, one staff member told us, "They need to have improvements like more veggies, we should promote more healthy food. Crisps and chips are given a lot." Another staff member told us, "Two people just have a lot of ready meals like shepherd's pie, there isn't a lot of nutritious value, we could offer nice foods."
● Staff had not consistently ensured the safety of foods. For example, some foods in the fridge needed to be used within weeks of opening, however there were no stickers on them to inform staff when they were first opened and when they needed to be used by.

The provider failed to consistently ensure people's nutritional needs were met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Following the inspection, the provider informed us they were committed to working closely with the service to make improvements regarding people's meals

Adapting service, design, decoration to meet people's needs
At the last inspection the provider failed to ensure care was designed to meet people's needs and preferences was a breach of regulation 9 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 the regulation.

● At the last inspection the environment did not suit people who had sensory needs. The service was run down and needed redecoration. At this inspection improvement had been made to the sensory room and overall appearance of the premises
● The sensory room in the garden had been updated and made accessible for people when they wanted to use it. The sensory room was storing some garden furniture so it was not a clear space free from trip hazards, however there was an improvement from the previous inspection. The front door to the sensory room was always open during inspection and was easily accessible. We observed people accessing the garden, which was spacious, however the garden needed to be tidied and made safe for use.
● The corridors and dining room were bright and fresh from the redecoration that had taken place. Staff agreed the decorating had made a difference but there were still some improvements needed to general cleaning in the home. People's bedrooms were personalised with items they chose.
● The service had adapted equipment for mobility to support people. For example, one person had an adapted wheelchair.

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.

- Care and support plans did not consistently evidence when a mental capacity assessment had taken place for people who could not consent. For example, one person needed hospital treatment as sedation was needed. There was no evidence in the persons care plan of a capacity assessment having been completed. There was no evidence to show how the decision to have sedation had been made in the person's best interests.
- The service failed to involve a person in a decision that directly affected them. One person was being supported to move out of their bedroom. The decision had been made on that morning without any discussion with the person or their relatives. The service also failed to speak to the person that morning and explain what was happening. The home manager told us the move was in the pipeline and a discussion had taken place previously with relatives. The home manager told us this discussion was not recorded and a date was not set. The move that morning was prompted by another person's needs changing .
- Staff told us what they knew about the MCA, for example one staff member told us, "We assume, unless proven otherwise that people have capacity." The staff also told us that no one in the home would be able to make complex decisions by themselves.

The service failed to consistently gain consent from people in relation to their care. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 requires improvement. At this inspection the key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff did not consistently respect peoples likes and dislikes regarding food and meals times. One person's care plan outlined if they disliked something they would 'close their mouth and use their hand to push the spoon away. This was an indicator they did not want any more. We observed a staff member offering this person a spoonful of food. The person kept their mouth shut and the staff member persisted seven to eight times before the person pushed the staff members arm away.
- The service were not respectful when they made a decision to move someone out of their bedroom. The persons personal and familiar items in their room had not been moved to the new room. One staff member told us, "It wasn't meant to happen today and we wanted to move the persons items not the maintenance staff, it would have been better if we could have done it with [person] and include them ."
- People with complex needs did not consistently receive support to eat and drink which met their personal preferences. Pureed meals were presented in a way that was unappetising, for example we observed burger and chips that had been blended and served in one bowl. The person was then unable to taste the different foods being given to them .

The service failed to consistently treat people with dignity and respect. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We observed care that was not always respectful. For example, one person was laying on the floor and a staff member told us this was usual behaviour for the person. The staff member said, "(Person) doesn't like this." and then proceeded to tickle the person, which made them get up off the floor. We intervened and advised the staff member that if the person didn't like it, then staff should not be doing it. This incident was highlighted to a member of the management team who addressed the concerns and had discussions with the staff involved.
- People did not have the opportunity to try new experiences, develop new skills and gain independence. One person's care plan outlined they would like to go to the zoo with their keyworker. There was no evidence this had happened or was being planned.
- We did observe some positive interactions. For example, we saw one staff member speaking to a person in a respectful way. Staff were attentive towards people. One staff member was concerned about someone feeling unwell and they allowed the person to rest on them and be comforted.

Inadequate

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 inadequate. At this inspection rating has remained the same. This meant services were not planned or delivered in ways that met people's needs.

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

At the last inspection the provider failed to ensure care and treatment was always provided that met people's individual and most current needs. This is a repeated breach from the last inspection of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this part of regulation 9.

● At the last inspection people were not supported to take part in meaningful activities and people's care plans lacked detail around what things they liked to do. At this inspection we identified the same concerns.
● People were not being supported to engage in meaningful activities. We looked at daily records and activities log chart for one person. During 23 days in August 2022 the person had only left the house twice. The daily notes detailed the person was 'agitated due to not going out' and '[person] calmed down when told they would be going for an outing with relative in 3 weeks time'. When we spoke to staff about why this person wasn't going out they told us, "[person] is active and would benefit from going out more, if we had more staff, we could do more."
● People were not being supported to pursue their interests or hobbies. For example, one person's support plan detailed they would like to attend the local church, however this was not happening. Another person's support plan detailed they liked country walks and would like to visit different parks, however this was not happening.
● During the two days of inspection, people were not supported to go out or supported to take part in meaningful and person-centred activities. One staff member said, "We struggle to keep people's attention."
● Relatives told us they were not updated about activities their loved one participated in. For example, one relative told us, "Communication could be better with what [person] has been up to." Another relative told us, "There is always an atmosphere in the home and its boring, staff sit around watching tv."

Care and treatment did not meet people's individual needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although care and support plans did not always detail people's likes and dislikes, regular staff were able to tell us this information. For example, one staff member told us, "[person] likes to go out for a meals and to

the pub."

End of life care and support
● People did not have end of life care and support plans in place. There was no information regarding funeral plans or the person wishes. Following inspection, the provider informed us of plans in place for improving end of life care planning.
● However people's care and support plans did identify and highlight if a person had a DNACPR (do not attempt cardiopulmonary resuscitation) in place.

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

● People's care and support plans detailed how people preferred to communicate. One person had a communication passport in place which identified they liked to use Makaton, picture cards and objects of reference to express their choices and wishes. However, staff had not received Makaton training. Makaton is a language programme that uses signs, symbols and speech to enable people to communicate.
● Two people's care plans detailed staff should use objects of reference to help them understand. However, during inspection we did not see staff using objects of reference to support people to communicate.
● One person's care plan detailed they needed staff to speak in short and clear sentences for them to be able to understand. We observed staff being patient and talking in short and clear sentences to the person. The service failed to deliver person centred care. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Relatives told us they would know how to raise a complaint or a concern.
● There was a complaints policy in place. The home manager told us they had not had a complaint, but concerns were raised by relatives regarding their loved one not participating in activities. A meeting was held with the relatives to discuss how they would go forward with this. However, there were still some concerns regarding activities and the flexibility that the person was able to make a choice to take part in an activity of their choosing.
● The home manager told us that if a complaint was raised it gets look into and dealt with, however relatives did not always feel their concerns had been resolved satisfactorily.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
At the last inspection the provider failed to have robust oversight of the service this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this part of regulation 17.

- At the last inspection the provider had not identified the impact of people not being able to take part in meaningful activities. At this inspection they had failed to make improvements.
- The provider had failed to ensure there was a robust system in place to have oversight of people's daily activities.
- The provider had failed to instil a culture of care in which staff promoted people's individuality and enabled them to develop and flourish. After a manual handling incident that occurred, as reported in the safe section of this report, senior management investigated the incident and told us there was 'poor practice' regarding the incident. Staff had completed their training but not consistently put this into practise. Poor practise is where staff fail to provide a good standard of care and support. Following inspection, the senior management addressed the concerns.
- The provider failed to ensure management were always available to support staff. Staff members told us, "We don't have enough support, they spend too much time in the office."
- The provider had not always ensured the home manager felt supported in the service. The home manager felt they needed more staff to help support people. A staff member told us, "The provider (senior leader representatives from the registered provider) doesn't work on the floor so has little understanding of safe staffing levels." Although after the inspection the provider detailed the support they had provided to the home manager, they had not had sufficient oversight of the service to ensure a safe and effective service was provided. This included ensuring sufficient staff were deployed each day to meet people's needs.
- The provider had made improvements to the service, such as redecoration of the dining room and hallway. However, staff members told us they felt not enough focus was being put on caring and supporting people but instead focusing on other issues, for example one staff member told us, "A lick of paint and new sofas won't do it, a number of staff have left since Christmas."
- One relative told us, "There is endless excuses as to why [relative] is not going out".

The provider failed to have robust oversight of the service and failed to make the necessary improvements

to the culture of the service. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection the provider had failed to undertake robust quality checks this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this part of regulation 17.

● At the last inspection the provider failed to undertake robust quality checks and ensure accidents and incidents were monitored. At this inspection similar concerns were identified.
● Governance processes were not effective and did not hold staff to account, keep people safe, protect people's rights and provide good quality care and support. The provider had failed to improve the service since the inadequate rating from the previous inspection.
● The provider and home manager had failed to ensure sufficient oversight of the recording of accidents and incidents. The provider was using an electronic system to record and provide an analysis of incidents and accidents. This system was not yet fully embedded as not all staff felt they have the confidence and knowledge to use the system. This meant not all accidents and incidents were being recorded on the online system. The manager did not have sufficient oversight of incidents and accidents. There was no analysis of incidents and accidents to identify any trends or patterns so that risks could be reduced.
● The provider had not ensured that staff had the training they needed to meet the needs of all people using the service or that the training was effective. The providers training matrix had identified a number of updates required for different training sessions, however the refresher courses had not taken place.
● Although the provider had invested in the service regarding redecoration, they failed to invest in other areas to improve the quality of care for people. For example, they had failed to ensure there was always sufficient staffing numbers to enable people to take part in activities as and when they wanted to do so.
● Relatives told us they felt there could be more communication with them and updates on what their relative had been doing, including activities around the home and healthcare appointments .
● The provider had failed to ensure there was oversight and management of people's specific health risks. Support plans did not consistently provide clear guidance to staff on areas such as epilepsy and dysphagia. The provider had failed to undertake robust quality checks. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to ensure that notifiable incidents had been reported to the Care Quality Commission under their registration. We identified four alleged incidents of abuse between people in the service had not been reported to CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
At the last inspection the provider had failed to adequately evaluate and improve care. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this part of regulation 17.
● At the last inspection the provider failed to ensure relatives were involved in the service and their feedback

sought and used to improve the quality of care provided. At this inspection similar concerns were identified.
● The provider had not worked well with the funding authorities when identifying people's assessed 1-1 needs. The provider was not able to tell us exactly how many 1-1 hours of support people were getting every day. Some people needed 2-1 support when leaving the service but due to the low number of staff this was not often possible. The provider was unable to demonstrate how 1-1 funding from commissioners was being used.
● Staff told us they felt there was a divide between the home management team and staff on the floor. One staff member told us, "It feels very them and us." Another staff member told us, "I don't feel like [managers] support us, it's the general feeling on the floor".
● Relatives told us they would speak to the staff or the home manager and bring any concerns they had to them. However, relatives told us that their concerns were not always addressed and acted upon when they were raised with staff and the management at the service.

The provider had failed to adequately evaluate and improve care. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had started up regular resident meetings for people to discuss items such as cooking, outings and decoration in the home. However, people were still not being supported to take part in activities they wanted. For example, it outlined they wanted to do more cooking, however there was no evidence of this in their care plan.

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 provider and home manager understood their legal duty regarding duty of candour. Relatives were informed when there was an incident or accident. One relative told us, "They told us about the manual handling incident after it happened."