Mr & Mrs J Boodia

Gables Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Gables Care Home is a care home providing accommodation and personal care to seven people aged 65 and older with a mental health diagnosis, dementia and a learning disability. People live in one adapted building.

People's experience of using this service and what we found
Risks to people were not always assessed, monitored and managed safely. There was no formal recording of people's behaviours to look for trends and themes. The management of medicines required some improvements around competency assessments and correct processes in place when errors had occurred. All other aspects of the administration of medicines was undertaken in a safe way.

The provider and staff had not received adequate training and supervision in relation to their role.

There was a lack of meaningful activities for people and staff lacked an understanding of people's needs. Care plans lacked detailed guidance and information on people's backgrounds and family history. There were no end of life care plans in place.

People were not always being treated in a caring and dignified way and people's choices were at times restricted. People's nutrition and hydration was being monitored; however, choices around meals and drinks were at times restricted. We have made a recommendation around this.

Quality assurance and governance systems were not effective in making sure risks to people were managed safely. Staff had not always been supported to understand and fulfil their expected roles and responsibilities.

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

Based on our review of all the domains:

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

Right support:
Not everyone was being supported in a way that enabled them to have choice and control in their daily lives. We found people had restrictions placed on them in relation to accessing the kitchen. There had not been

an assessment of any risk associated with this.

Right care:
Care was not always person-centred and did not always promote people's dignity, privacy and human rights. People did not always have access to meaningful and person-centred activities.

Right culture:
Ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives. There were institutionalised practices where care was decided for people rather then people being supported to remain independent.

Rating at last inspection and update
The last two ratings for this service were Inadequate (published 07 June 2021 and 17 August 2021) and there were breaches of regulation. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating and to follow up on action we told the provider to take at the last inspection.

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

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report.

Enforcement and Recommendations
We have identified breaches in relation to the safe care and treatment, training and supervisions of staff, lack of adherence to the principles of the mental capacity act, people not always being treated in a caring and dignified way, the lack of meaningful activities, staff being aware of people's care, and the lack of robust oversight of the care provision 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 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 overall rating for this service '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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Gables Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Gables Care Home 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. Gables Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This 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. The provider was also the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with four people to gain their views on the quality of care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the provider four members of staff. We reviewed information held in five people's care plans, three staff recruitment files, medication records and other paperwork related to the running of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training and supervision records.

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 has remained 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

At our last inspection, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to manage risks associated with people in a safe way. Although some improvements had been made, we continued to find concerns at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- Risks to people were not always appropriately assessed or measures taken to enable people to live safely in their home. One person had bed rails fitted to their bed, however there was no risk assessment in place. The provider told us they had not assessed or considered the risk associated with bed rails including possible entrapment and entanglement in the bed rails.
- The same person also had a reoccurring wound on their head. There was no risk assessment in place in relation to the wound, or care plan detailing the care and treatment that was required. The provider told us they were aware of the wound and said they had observed it was, "wet". However, there was no record of how they were managing this. There were also no body maps in place to track the wound.
- The management of risks associated with people's mental health was not being managed in a safe way. One person's care plan stated the person's mental health had been stable since they moved to the service. However, according to their health care notes the person went through a period of frequently calling paramedics, and the Police whilst at the service. There was no risk assessment in place in relation to their mental health, or guidance for staff on how best to support the person.
- Another person had a secondary condition as a result of their mental health. There was no risk assessment in place in relation to this. The guidance in place for staff was limited to, "Confront [person] and support to overcome their obsession, check their room and confront [person]." The guidance did not include any strategies to support the person who, the provider told us, used this behaviour to make themselves feel better.
- Staff told us they had not read people's care plans and their understanding of the risks associated with people's care was limited to what the provider had told them. One told us, "I do not know these [risk assessments] deeply. I have no awareness of any of these."
- A third person had behaviours where they became anxious. This behaviour was recorded by the provider in the person's health care notes in April 2022. The provider told us this behaviour was likely due to them requiring their monthly medication. The provider said they had noticed this happened at the same time each month. However, there was no record of other occasions where the person had anxiety. There was missed opportunity for the provider to look for trends and themes to determine what steps needed to be

taken to support the person.
● The plans in place for people who may need assistance to evacuate the home was not always reflective of people's current needs. One person's cognitive impairment had reduced; however, their evacuation plan stated the person would be aware of the fire alarm and to leave the building. Another person required a walking aid, but their evacuation plan stated they were independently mobile. This meant the person may not receive the appropriate support in an emergency.
● We found an element of the administration of medicines that required improved. We saw one person had been given their medicine out of sequence. The provider had not picked up on this error and there was a risk staff may have believed the person had not received their medicine on the day it was intended. The initial response from the provider was that the person taking the medicine would be able to tell them they had already had the medicine. We discussed with the provider they should not rely on this.
● The provider told us they assessed a senior member of staff's competency to administer medicines. However, they told us the same member of staff would then assess the providers competency. Care home providers should consider using an 'accredited learning' provider so that care home staff who are responsible for managing and administering medicines can be assessed by an external assessor.

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

● People told us they received their medicine when required. One told us, "I get pain killers when I need."
● People's medicines were recorded on medicine administration records (MARs) and were easy to read. The MAR chart had a picture of the person and details of allergies, and other appropriate information. There were medicines prescribed on 'as required' (PRN) basis and these had protocols for their use.

Staffing and recruitment

At our last inspection, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to their not being sufficient staff to meet people's needs in a safe way. Although the provider remains in breach of Regulation 18 (see effective domain) they had met the requirements in relation to staff levels.

● People told us there were enough staff to support them. One person told us, "When we need support, I always get help. There's enough staff. Staff are good."
● At the previous inspection we found there was no waking staff at night. At this inspection people and staff confirmed with us there was a member of staff awake at night. One member of staff told us, "I am awake the whole night. For [person] I need to check her every hour, if I'm not awake how can I check her status?" We saw daily notes recording the care that had been delivered during the night shift.
● During the inspection we saw staff responded to people's needs quickly. Where one person required two staff to support them there was always sufficient staff to support with this. A member of staff told us, "I think there are enough staff. There are sometimes four in the morning to help with medical appointments. Whatever needs to be done, I am doing it."
●The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt comfortable with the care staff. One person told us, "I feel safe, the place itself

makes you feel well looked after. The carers are very good. No worries there." However, there were people who had restrictions in place that had not been consulted on and people did not feel able to raise their concerns or how they felt about it.

● Staff understood what constituted abuse and the procedures to take if they suspected any type of abuse. One told us, "It's about protecting adults and keeping them free from abuse." Another told us, "The process is we have to report it to the [LA] safeguarding team and to the manager."

● We reviewed the incident reports and safeguarding folder at the service. There had been no incidents raised since the last inspection. The provider told us that there had been no safeguarding concerns raised that required to be reported.

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 using PPE effectively and safely.

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

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

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

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

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

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the inspection in April 2021 this key question was rated as Inadequate. At this inspection this key question has remained Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

At the April 2021 inspection, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the requirements of MCA and consent to care and treatment were not being followed. We continued to find concerns at this inspection and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's rights were not being protected because the provider and staff were not acting in accordance with MCA. There were people at the service that were having restrictions placed on them despite having capacity to make their own decisions. One person told us they were being restricted from entering the kitchen. The person told us how they felt about the restriction, "Going into the kitchen is a no no from [Provider], it was embarrassing." The provider told us the person was not allowed in the kitchen but acknowledged this was not due to a risk of harm to the person or others.
- A member of staff told us the same person was also told by staff they could not go out without a member of staff. "[Person] has [health condition] and does not go out alone……we have to be very careful with [person], cannot let [person] out on their own. [Person] understands these restrictions. They have to let us know when they want to go out." The care plan had no information around this, and the provider told us the person had full capacity to make their own decisions. This meant restrictions were being imposed on them without applying the principles of MCA. The person told us they did not like being restricted in this way.
- Another person told us they were also told they were not allowed to go into the kitchen. They said, "We're not allowed into the kitchen, if we are found in there, they might get a bit angry." There was nothing in the

person's care plan to state there was any risk related to the person going into the kitchen. The person also told us they were also restrictions placed on them in relation to the types of food they were able to have.
● Where other decisions were being made for people there was no evidence that their capacity had been assessed. One person had a bed rail and had a lap belt when they used their wheelchair. The provider told us that this person lacked capacity to make decisions. There was no assessment of the person's capacity to determine if they had capacity to agree to the bed rails and lap belt. There was no evidence of a discussion to determine that this was in the person's best interest or whether less restrictive measures had been considered. There had also been no DoLS application submitted to the Local Authority in relation to the restrictions.
● The provider told us the same person had family involved in their care who were able to make decisions about the person's health and welfare (Lasting Power of Attorney 'LPA'). However, when we reviewed the LPA information this only related to the person's finances.
● We saw that decisions had been made about the person's medical treatment without a capacity assessment or evidence of a best interest discussion to determine if this appropriate. The provider told us, "If [relative] hasn't got health and welfare (LPA) then he can't give consent." However, the provider had not checked this was in place.
● Despite the provider telling us the person did not have capacity to make decisions, we saw they had asked the person to sign a Covid-19 vaccination consent form.
● The provider and staff lacked an understanding of the principles of MCA. One member of staff told us, "I think I need to learn more." Although one member of staff was able to describe the principles, they were not applying this. The member of staff told us, "It is not up to me to decide what I should do on their behalf. In general people can decide what they want for themselves and we support them to do this." However, the same member of staff told us about them restricting one person from entering the kitchen. According to the training record only five staff out of 10 had completed MCA training.

As the requirement of MCA and consent to care and treatment was not followed this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

At the April 2021 inspection, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to staff not having effective training and supervision in relation to their role. We continued to find concerns at this inspection and the provider was still in breach of regulation 18.

● Staff had been provided with online training. However, we noted multiple modules of training were completed by staff on the same day with no evidence of how the provider assessed their understanding of the training. The provider told us online training was not the most effective way of learning, but there was no evidence of any additional training they had provided. They said, "I agree with you. It is important to be in a classroom so that they can speak and discuss with each other what they have learned."
● The training was not always effective in ensuring staff were competent to provide appropriate care. We identified shortfalls around the management of risks and the lack of understanding of the principles of MCA.
● Other training specific to the needs of people was not always being completed by the provider and all of the staff. For example, there were people who had a learning disability, yet according to the training record provided, only one member of staff out of ten had completed training around this. Another person was living with dementia yet only five staff had completed dementia care training. The provider had not had training in either of these areas.
● Staff told us they completed supervisions with the provider; however, when we asked to review the

records they had not been recorded. This was despite the providers policy stating supervisions needed to be recorded to include, "Completion of appraisals and objectives, and personal development planning." One member of staff told us, "I sit and discuss with [provider] in the office, but I cannot remember when I last did this."

● Supervisions with staff to assess their performance and to provide support were not adequate. The provider told us one member of staff was not supporting people without other staff around until they felt they were competent to do. However, we identified through staff rotas that the member of staff was working nights shifts on their own without a competency assessment taking place.

● The member of staff told us they were still learning about people and acknowledged there was more they needed to understand about people's needs. They told us, "The caring role is only at an elementary level." We asked the member of staff about the wound on one person's head. They told us, "I'm not sure on this. When it happened, I was not here." This meant the provider could not be confident the member of staff would provide the most appropriate care.

As there is lack of effective staff training, knowledge and competency this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

At the April 2021 inspection, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was an inconsistent approach by the provider to ensure that people had the involvement of health care professionals in relation to their care. Although the provider remain in breach of Regulation 9 (see responsive domain) the provider had met the requirements in relation to this; however, some improvements were still required.

● The provider consulted health care professionals in relation to people's care. One person told us, "I don't need the doctor. If I need it, I just mention it."

● People had appointments with mental health teams [CMHT] and were referred appropriately when staff were concerned.

● People had access to a GP, dentist and an optician and could attend appointments when required. On the day of the inspection an appointment had been planned for one person to see a GP.

● However, we noted the health records around people's health care input were difficult to navigate. Where appointments had taken place, staff were recording the appointment but not always the outcome. We discussed this with the provider who told us they would ensure this was done.

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

At the April 2021 inspection, we identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to people not always having their nutrition appropriately monitored. We found they had met the breach of regulation 14; however, some improvements were still required.

● People were not always given choices in relation to the meals. On the day of the inspection one person was supported with their lunch. The person was unable to verbally communicate their choice and staff did not offer them a visual choice. Another person fed back they were unable to have sugar in their hot drink. They told us, "I don't get sugar here in my coffee, most say I don't need it." There were no health reasons as to why the person was not able to have sugar.

We recommend the provider offers choices of meals to people around their preferences.

● Despite this we saw people were provided with drinks throughout the inspection and were also encouraged to make their own drinks. The menus were on a rolling four-week cycle and there were two options. However, the second option was mainly limited to an omelette or a salad.
● The provider was weighing people each month and where any concerns were identified the provider consulted health care professionals in relation to this.
● People told us they liked the food at the service. Comments included, "The food is very good, good for me" and "We have nice meals, very nice."

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The corridors and rooms were spacious to allow people to move freely. The lounge and communal areas were tastefully decorated with modern fixtures and fittings. There were separate lounges for people to have their personal space.
● There had been no people admitted to the service since the last inspection. We saw the provider was now using recognised good practice and national-recognised assessment tools to assess the needs of people. This included skin integrity assessments and nutritional tools to assess whether people were at risk.

Requires Improvement

Is the service caring?

Our findings

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

At the inspection in April 2021 this key question was rated as Requires Improvement. At this inspection this key question has remained 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; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

At the April 2021 inspection, we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not always treated with dignity and respect. This had not improved at this inspection and the provider remains in breach of regulation 10.

● Not everyone was being supported in a way that enabled them to have choice and control in their daily lives. Some people fed back they were told when they needed to go to bed. One person told us, "[Provider] will come in and say, 'Bed' but not in an aggressive way. She just says, 'It's time for bed'." Another person told us, "When [provider] is on she sends us to bed. I don't get really tired and I would like to go a bit later, or when I just want to go."
● People also fed back that at times they were not spoken to in a dignified way. One person said they were told to go to bed early as a consequence of them going into the kitchen. The person said they, "Felt slightly treated like a child." Another person said, "We never get a drink late at night. I never ask because I know what [providers] answer would be. She would say something nasty."
● The wording of the guidance the provider used in people's care plans in relation to their mental health was not always written in a dignified and respectful way. The care plans directed staff to tell people that what they were doing was not acceptable and, "Not to do it again." People were also asked to write statements in response to this which again were not dignified for people with one note stating, "I know it's wrong. I won't do it." According to the training record the provider had not undertaken any training in relation to care planning or person-centred care, despite this being listed as a requirement.
● People's choices and preferences were not always respected. One person was unable to verbally communicate their needs due to living with dementia. Their care plan stated they did not like fish. This was also confirmed to the Local Authority by the provider when they visited the service in February 2022 and observed the person had been given an alternative to the planned meal of fish and chips. However, on the day of the inspection we saw the person being given fish for lunch. We questioned this with the member of staff who told us the person, "Loved fish and all food."
● The provider had a residents meeting with people to discuss their, "Personal Hygiene." People were asked to respond to the discussion, which was recorded, to state they agreed with the providers expectations. However, there were people with continence issues so this would not have been dignified for them to respond to particularly in front of their peers at the service.

As people were not always treated in a caring and respectful way this is a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did feed back staff were caring towards them. Comments included, "Staff are very caring and very helpful" and "Staff are caring, kind. I think the staff in general are quite kind."
● We saw examples of staff being caring and considerate to people. When people returned from their day centre staff greeted them and asked them if they enjoyed their day.
● There were people who told us they were able to go to bed and get up when they wanted. One person told us, "I'm fairly independent with this."
● One person told us they felt their confidence had grown since living at the service. A member of staff said, "One person is a very private person. Slowly we won their confidence and now finally they trust us to help them."

Requires Improvement

Is the service responsive?

Our findings

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

At the inspection in April 2021 this key question was rated as Requires Improvement. At this inspection this key question has remained 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; End of life care and support

At the April 2021 inspection, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people's care and treatment was not appropriately planned around people's needs. At this inspection this had not improved sufficiently, and the provider remained in breach of Regulation 9.

● At the previous inspection we found there was not always sufficient and up to date guidance in the care plans around the specific needs of people. The plans did not provide staff with enough information so they could respond positively and provide the person with the support they needed in the way they preferred. Although we saw the Provider was starting to include people more when writing care plans, the concerns remained at this inspection and there was little change in the care plan guidance for people with a mental health diagnosis.
● One person had a mental health diagnosis and the care plan stated their mental health was currently stable. However, there was no guidance on how the person may be affected by this or how staff should support them should they have a relapse. There was evidence in the person's daily health notes they had episodes of anxiety; however, their care plan had no information on how they person needed to be supported.
● Another person's care plan stated they had a condition that weakened their bones. The person also told us they had frequent pain in their back which was evident from their posture. There was no information on how the condition affected the person and how staff needed to support the person with this. A third person had a diagnosis of dementia but there was no detail of the type of dementia and how staff needed to support the person with this.
● There were care plans that lacked information and details regarding people's life histories, important people in their lives, personal preferences and emotional and social needs. Care plans had not always been reviewed effectively to make sure they were comprehensive, accurate or up to date. One member of staff told us, "I am not familiar with the residents, their backgrounds and history. It's important, I will understand more about the residents." This increased the chance that staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life.
● People had not been supported to develop end of life care plans. There was a lack of information and planning around any emotional and spiritual support needs and preferences as they were approaching the end of their life.

Care and treatment was not planned to meet people's individual and most current needs. This is a repeated

breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them;

● There were mixed responses from people about the activities on offer to them. Comments included, "I think there is enough activities to do. Now and then I get bored, more so at weekends", "You can read, write letters and you can go for a walk. Theatre or cinema would be nice", "At weekends I never go out" and "At weekends I rely on my family to take me out."

● People were not being supported to engage in meaningful activities. On the day of the inspection people had been to a local day centre which people told us they enjoyed. However, when we reviewed people's daily notes the majority of the external activities were at local day centres. According to their daily notes, over 23 days one person had been out on five occasions and each time was to a day centre.

● The activity board at the service detailed activities taking place each day. This included bowling, quiz, seated exercises and gardening. When we checked people's daily notes there was no evidence these activities had taken place or that people had been offered and refused the activity.

● Through meetings the provider had asked people what activities they wanted to take part in. People fed back they would like to go to the cinema, theatre, the seaside, shopping and going out for meal. There was no evidence from the daily notes these activities had taken place. One person fed back to the provider they would like to learn a new language; however, there was no evidence the person had been supported with this.

As meaningful activities were not provided to people this is a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

● As found at the previous inspection the majority of people living at the service were able to communicate without difficulty. However, for those who were unable there remained no information in their care plans on how best to communicate with them. Care plans were not written in an accessible way for people, including for the person with a learning disability. The lunch menu was typed up in small print and left on the mantlepiece. However, for those unable to read this there was no alternative format offered such as pictures or larger print. We did not see a person being offered a visual choice with their meal.

Improving care quality in response to complaints or concerns

● People we spoke with told us they would know how to raise a complaint. However, people also told us they did not always feel comfortable raising concerns with the provider.

● We reviewed the complaints folder and noted there had been no recorded complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

At our last inspection of the service, we found the provider had failed to have robust systems in place to monitor the quality of care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

● The provider's governance framework had not been effective in ensuring staff were aware of their responsibilities and that a good standard of care was sustained at the service and relevant legal requirements were met. Since the last inspection there remained multiple breaches of regulations, placing people at actual and avoidable risk of harm to their well-being.
● There remained no effective systems in place to quality assure the care being provided. The provider wrote the care plans but there was no audit of them to review the quality. The provider told us, "You may have seen I am updating all of the care plans." However, the lack of detail in the care plans was identified at the inspection in April 2021.
● The provider was counted in the staff levels on each shift they worked. This meant on top of providing care to people they were also having to complete management duties. There was no evidence of audits or checks to ensure the care being delivered was appropriate. Concerns we identified were not being picked up as appropriate audits were not taking place.
● The provision of care and support was not tailored to meet the needs of people and people were not always encouraged to do what they can for themselves. The provider and staff were not always enabling people to live fulfilled lives safely, rather they were restricting people's reasonable freedoms.
● Examples of this included a person not being able to go out without a member of staff despite them having full capacity and no mobility issues, people being restricted from accessing the kitchen, people being restricted from making food choices if considered unhealthy by the provider.
● At the previous inspection there were instances where the provider gave us incorrect information relating to questions we posed to them. At this inspection we found the provider was not being open and transparent when requesting information. The provider told us of one member of staff, "[Staff] is never working on her own." However, we noted from the rotas the member of staff worked on their own at night.
● Statutory guidance was not always followed in relation to people's care. We found the provider was not meeting the Right Support, Right Care, Right Culture guidance in relation to the support provided to people

with a learning disability.

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

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

● Although people had the opportunity to attend residents' meetings these were not used as an opportunity to make improvements. One person told us, "They are a good idea, but I find I don't get much from them." When we reviewed the minutes of the meetings, we found people had been asked about activities they wanted. However, there was little evidence of changes that had been made as a result of the feedback.

● We did not see evidence of surveys for people or staff so the provider could gain vital feedback from on how they were performing in the service. The provider told us after the inspection these surveys did take place.

● Opportunities to make improvements to people's care were missed as there was no robust analysis of incidents and behaviours undertaken by the provider. There was no meaningful information to determine where improvements could be made.

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

● Staff told us they felt supported and held meetings each month. One member of staff said, "We have meetings each month with people; they talk about anything they like; we are open to what they need at any time." Another told us, "We have meetings one or two a month, during the meeting we can share what we see and need to improve and what we need to do in the future to improve our work to improve the standard here."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● Where incidents had occurred, we noted from the records that families were contacted. We saw feedback from relatives who had been made aware of any changes to their loved one's health.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including an incident that had occurred.

● We saw evidence the provider worked in consultation with funding authorities in relation to people's ongoing placements at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was planned to meet people's individual and most current needs

The enforcement action we took:

We have cancelled the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were always treated with dignity and respect.

The enforcement action we took:

We have cancelled the providers registration

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 to ensure risks associated with people's care was managed in a safe way

The enforcement action we took:

We have cancelled the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to adequately evaluate and improve care and failed to undertake robust quality checks.

The enforcement action we took:

We have cancelled the providers registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider there was effective staff training, knowledge and competency

The enforcement action we took:

We have cancelled the providers registration