Hunters Moor 929

Orchard House

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Orchard House is a 'care home' registered to provide accommodation and personal care. The service is a neurological rehabilitation centre providing specialist community-based transitional rehabilitation for people with brain and spinal injuries, stroke, minimally conscious states, and a range of progressive neurological conditions. The service could support up to 11 people in one adapted building with communal areas. There were 10 people living at Orchard House at the time of the inspection.

People's experience of using this service and what we found
The provider did not operate effective quality assurance systems to oversee the service. These systems did not identify shortfalls in the quality and safety of the service or ensure that expected standards were met.

The provider did not ensure consistent actions were taken to reduce risks to people and plans were not in place to minimise those risks. The management of medicines was not always safe. Not all staff were up to date with or had completed mandatory training. Staff did not receive regular supervisions, spot checks and team meetings were infrequent.

Staffing levels did not always support people to stay safe and well. Staff members did not always treat people with warmth, dignity and respect when interacting with people. People were not always supported to express their views using their preferred method of communication.

The service did not ensure that clear and consistent records were kept for people who used the service and the service management did not always inform CQC about notifiable incidents.

People, their families and friends did not feel that they were involved in the planning of their care. Care plans did not always contain information specific to people's needs or contain information on how to support people to manage any conditions they had, and in most cases up to date care plans were not in place. Staff were not provided with detailed guidance to follow when supporting people with complex needs.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Activities were limited and not all people using the service had access to available therapies.

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

Rating at last inspection
The last rating for this service was outstanding (published 14 March 2019).

Why we inspected
We undertook a focused inspection of the key questions of safe and well-led to follow up on specific

concerns which we had received about the service. The inspection was prompted in part due to concerns received about safety of the service. These concerns were around up to date and accurate records and risk assessments not in place. There were also concerns about the effectiveness of the management in relation to governance by ensuring the service was safe and of a high quality. A decision was made for us to inspect and examine those risks. We inspected and found there was a concern with other areas of the service, so we widened the scope of the inspection to become a comprehensive inspection which included all key questions.

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.

The overall rating for the service has changed from outstanding to inadequate based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to good governance, person centred care, safe care and treatment, staffing, need for consent, safeguarding, duty of candour and fit and proper persons employed at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not 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 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

Orchard 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.

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 2 inspectors.

Service and service type
Orchard 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. Orchard 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for five months and was planning on registering to become the registered manager but had not yet submitted their application.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with the manager, the operations director, 4 rehabilitation assistants, 1 agency member of staff and a cook. We also spoke with 3 people using the service. We looked at records including 4 care plans, 4 staff files, including information about recruitment. We also looked at a range of records relating to the safety, quality, and management of the service. We sought feedback from 1 relative of those in the service, and healthcare professionals who visit the service.

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.

After the inspection we spoke with the nominated individual, and the managing director. A nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks associated with people's care was not always managed in a safe way. Care plans and risk assessments were not always in place or up to date. There was no relevant information in place to signpost or mitigate people's risks. We did not see appropriate documentation that identified the action necessary to support people to live safely or inform staff of what their role was and what support individuals required.

● Where staff were required to support people with repositioning, there was no guidance, documentation or records available on how to best support people to reposition and the risk around this. Staff were unsure of how often people needed to be repositioned. This lack of information and guidance posed a risk care staff may not be clear of their roles and responsibilities when delivering care which could lead to harm occurring.

● Risk management plans had not been consistently developed for specific healthcare conditions such as; dysphasia and Huntington's disease.

● The provider had not taken robust safety measures to reduce risk. We saw incidents such as falls had taken place, but care plans had not always been updated so staff could reduce incidents occurring again.

● Assessments were not reviewed regularly to ensure they included up to date information around the risks to people. For example, one person had risks associated with weight loss in association with their deteriorating condition and also skin integrity. Their risk assessments had not been updated with guidance for staff on how best to support them, and documentation did not always contain dates. This meant there was a risk staff would not provide the most appropriate care.

● We saw that some people had equipment in place to support them, but there was limited evidence of guidance regarding how to use equipment safety. This was echoed by staff who said that it was not always clear what was expected of them. For those that needed new equipment, we heard this was not always implemented or timely.

The failure to ensure people received a safe service was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safe Care and Treatment.

●Following the inspection, the provider was asked to ensure risk assessments were in place for all people. They assured us that all residents would have a one page summary in place and that risk management plans were being worked on.

Staffing and recruitment

●The service did not ensure appropriate staff recruitment checks were obtained prior to employment. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that certain information must be obtained in respect of people employed.

●At the time of inspection there was no maintenance worker employed by the service. We heard that a

relative of a staff member often came in, in their own time and carried out maintenance work. It was unclear if this person had been DBS checked, as there were no records in place to evidence this person worked for the service. After the inspection we were informed that the provider had 2 maintenance assistants who cover Orchard house. We were not provided with any evidence of the involvement at the service.
● Required recruitment checks on staff were not always made. We saw staff working for the company did not have all the relevant documentation in place. For example there were gaps around the employees previous employment, interview records were incomplete, and for in 1 staff file viewed, there was no information on file they had been DBS checked. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This meant unsuitable people may have been recruited as a result.

Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Fit and proper persons employed.

● Staff we spoke to confirmed that often it was difficult to ensure that safe levels of staffing were available. When people required support with personal care there was often times where nobody was on 'the floor' engaging with residents.
● People did not always feel they were asked about preferred staffing gender. One person's relative told us they had expressly informed the service that the person preferred men and had requested that at least one permanent staff member work with their relative. We heard this was not always possible due to low level of permanent staffing.
● Medical professionals felt that staffing appeared to be an issue at the service, they commented that staffing continuity was key when supporting residents with complex neurological disorders.
● The majority people at the service required support from 2 staff in regards to personal care and 3 people who required one to one care. This meant that there would be times in which there were no staff available to support others. This was evidenced by speaking with staff, and viewing the rota with management. We were informed that there were currently 11 staff vacancies at the time of inspection. We saw that lack of staffing had previously been brought to the providers attention by staff. The provider informed us they had increased the staffing payment to attract more applicants and were in the process of recruiting staff.
● A high number of agency care staff were deployed at Orchard House, people felt this was having a negative impact on people using the service. We did not see information in place that would enable new starters/agency staff to understand peoples support needs and risks.

The registered person failed to evidence that staff were suitably supported, qualified and skilled. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Staffing.

Using medicines safely
● Safe medicine practices were not promoted. Records did not always confirm enough suitable staff had been trained adequately in administering medicines safely.
● People who required PRN [when required medicines] such as pain relief, were unable to access this when needed as evening staff were not trained to administer medicines, meaning people were unable to access pain relief from 8pm until 7am.The provider had previously been made aware of this, however they had not taken action to ensure people had access to medicines.
● Not all staff were able to administer life saving medicines such as Midazolam which supports someone when having a seizure. The provider was asked to implement training for all staff in order to ensure peoples

safety.
● The services PRN protocols were not up to date for people who required life saving medicines. Medicine folders contained contradicting information about the dosage and guidance when someone required this medicine, and staff were not always aware of new guidance. One file contained outdated information that had not been removed, this person was at risk of receiving too much of the medicine. The service removed this contradicting information when asked to do so.
●Controlled medicines were audited, however processes in place to account for medicines were not always documented accurately. Medicine audits confirmed that liquid medicines and controlled medicine stock levels were accurate, however we saw that controlled medicine stock was not recorded accurately. Medicine audits had not identified the shortfalls found on inspection and contained incorrect information. The manager assured us that this would be rectified.

The service failed to ensure safe management of medicines. The failed to ensure that staff were suitably trained to support people with medicines. This was a breach of Regulation 12, Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked the provider to take immediate action to ensure staff were appropriately trained. We were provided with an action plan demonstrating how they would achieve this.
● We were informed following the inspection that this training has been booked for the remaining permanent staff, and for regular agency staff.

Systems and processes to safeguard people from the risk of abuse
● Systems were not in place to safeguard people. During the inspection we saw there were times in which safeguarding and other incidents such as choking and falls had not been raised by the service and where CQC and other relevant bodies such as the local safeguarding board had not been notified. This meant there was no assurance that incidents were being investigated and acted upon appropriately by the provider. The service director asked for a list of these incidents after the inspection in order to take action to investigate these concerns.
● Staff were not up to date in safeguarding training and practice. Staff we spoke to were aware of incidents in which a safeguarding may have been raised and were able to tell us how they would raise their concerns in order to keep people safe but were not always sure how they would escalate these if concerns continued.

The service had failed to implement effective systems to identify, investigate and appropriately respond to allegations of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection; Visiting in care homes
● People were not always supported to live in an environment with good infection prevention and control (IPC) processes.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home, such as the stairs were visibly dirty and there were no hand towels in the communal toilet downstairs or in a number of people's bathrooms. The manager said a delivery of hand towels had been returned due to not being able to offload them into the premises. There were no alternative actions taken to provide suitable hand drying facilities during this time.
● Some fittings and furniture would not allow for the prevention of infection due to their deterioration such as rust or peeling. This had not been picked up on bedrooms audits as they had not been completed.
● We found gaps in recording of cleaning. We reported this to the manager who said the cleaner had left and it was up to staff to clean the premises.

● The IPC framework audits stated all staff had received IPC training; however this was not evidenced on the training matrix.
● We were not assured that the provider was responding effectively to risks and signs of infection. A recent hand hygiene audit identified that further training was required and that training had been implemented. The training matrix did not evidence that such training had taken place.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

The failure to provide care and treatment in a safe way is a breach of regulation 12 (1)(of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Safe care and treatment.

● 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's infection prevention and control policy was up to date.
● The provider followed government COVID-19 guidance on care home visiting. Visitors were welcome at any time into the home to visit their loved ones.

Learning lessons when things go wrong
● A whistleblowing concern was raised in January 2023 with numerous concerns. These were shared with the provider's nominated individual who arranged for the concerns to be investigated. The outcome of this included actions about ensuring people's weights were routinely monitored and recorded. We found this had not taken place when we inspected. The report also said that risk assessments and management such as eating and drinking would be added to support plans. The support plans had not been updated since this investigation.
● Lessons learned were not always evidenced as being communicated effectively. We saw that one staff meeting had taken place and there was a communication handover log in place, however information within this log was not always clear and meetings did not demonstrate lessons learnt or individual risk. This risk was mitigated as people we spoke to were aware of individual risk.

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 our last inspection we rated this key question outstanding. At this inspection the rating has changed to inadequate. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The provider failed to ensure people's needs had been assessed, monitored and managed in line with best practice guidance. Care plans and risk assessments did not contain updated, factual information.
- The service quality team had recently spent time at the service working on implementing peoples care plans. We reviewed these care plans however they were unfinished and contained incorrect information, such as the names of other people and incorrect diagnosis. The provider acknowledged learning from this, best practice was discussed with the service manager such as involving staff that know people and their needs well in the development of accurate care planning.
- Although there were evidence based tools available to the service, we did not see these effectively used to identify and meet people's needs. There was mixed information about the commissioning and entitlement of people in regard to who should be receiving rehabilitation. Therefore, it was unclear which people needed active rehabilitation plans in place and whether their assessed needs were being met with the appropriate care and support. We did not see any rehabilitation or therapy care plans in place.
- The provider failed to have systems in place to implement best practice in the care of skin pressure damage and oral health assessments. There was no guidance about how often people needed to be repositioned to prevent pressure ulcers. Peoples care records did not include oral health assessments; there was basic information in available care plans stating the person needs support to brush their teeth without any details about the type of brush or tooth paste or how often the person needed to attend dental appointment. This placed people at risk of unsafe care.
- There was no evidence the service had assessed people's compatibility with each other, or their sensory needs. One person expressed themselves through loud vocalizing. We heard this to also be the case at night. The service had not considered the impact of noise on other people's sleep and wellbeing and there was limited evidence available that demonstrated the consideration of best action to take to support the person.

The service did not ensure that care plans fully identified or met people's needs. This was a breach of regulation 9(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Person centred care.

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

- Risks associated with eating and drinking were not always effectively managed. The International Dysphagia Diet Standardisation Initiative (IDDSI) framework provides descriptions of food textures and drink thicknesses to improve safety for people with swallowing difficulties. Kitchen staff were not aware of this guidance, when asked, and were not able to tell us what peoples required safe levels of food and drink were.

The provider was asked to take action to ensure that the chef had adequate training in place. Following inspection we were informed that the interim chef had been signed up to complete further training as also recommended by the SALT (Speech and Language Therapy) team who attended after the inspection. There was no guidance seen within the kitchen, and information/ records for food and fluid charts were unclear and not always completed. This meant people were at risk of inaccurate diet textures and drink consistencies that could cause choking.

● During the inspection food menus were not available, daily food options were written on a whiteboard. Some staff felt that people were not always asked about what they might like to eat and felt they did not always have access to enough fluids. This placed people at risk.

● Peoples needs were not always assessed to ensure they received safe care and treatment. We heard from a relative that if people refused food they were not always provided with another option, "I don't think [person] has enough fluid. They [staff] do keep records, we've asked if [person] doesn't drink [their] squash can [person] have a cup of tea and [person] doesn't get that." We also heard from a relative that their relative requires breaks during mealtimes, on occasions they have witnessed agency staff taking food away as they believe the person is finished. Relatives brought this to the attention of management but felt there had been no improvement.

● Records around food and fluid were not always filled out adequately and were not monitored in order to ascertain if people were receiving enough food and fluid. Staff we spoke to recognised that record keeping was not always completed to a high standard and that further training around expectations should be delivered to all new starters and agency staff. Relatives of those using the service told us "I don't know whether [staff] write all the drinks in there [food and fluid chart]. For 2 weeks there was nothing in there at all and there was nobody I could ask."

The provider failed to ensure people's needs were assessed, monitored or managed safely. This was a breach of regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014- Safe care and treatment.

Staff support: induction, training, skills and experience

● The provider failed to ensure suitably trained and supervised staff were deployed to meet people's needs. Not all staff felt that they had the skills to support people, and access to further training if required.

● The training matrix did not contain information for all staff working for the company, therefore we were not assured that all staff had relevant training as not all staff were up to date in safety-related and other training to meet people's assessed needs. Therefore, we were not assured that staff had the necessary training to provide safe care or that the provider had oversight of the training required to meet people's needs.

● We saw one person was visited by the district nurse to support them with their catheter. Staff told us they were able to change the catheter bag with minimal training. We were made aware that previously specialist training had been provided around catheter care, however the current training in place for staff was to observe other staff carrying out this care. We did not see this training documented on the matrix.

● Agency staff did not always have the skills or knowledge to support people at the service. They were not provided within inhouse training from the service around people's needs such as acquired brain injury and Huntington's disease, however commented that they felt supported by senior members.

● A review of agency staff inductions evidenced that they did not always have access to up-to-date information about people's needs due to the lack of up-to-date care plans and information available to highlight important areas of need such as a one-page profile. These were put in place by the second day of the inspection, the profiles did not evidence where to access full guidance around areas such as epilepsy or nutrition.

● We received mixed feedback from staff about support available. We heard staff did not receive regular

supervisions and did not always feel supported in their roles. We also heard that current management had arranged one to ones and some staff had received supervision. Supervisions were not consistent, and spot checks were not evidenced. The provider was unable to demonstrate systems in place to determine when spot checks and supervisions were due or had occurred.

The provider failed to ensure staff were competent to provide safe and effective care. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Staffing.

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.

● The requirements of the MCA and the need to consider the least restrictive options when developing people's plans of care had not been implemented. Consent to treatment was not always obtained, evidenced or effective.
● We saw limited documentation in place to support that people were involved in decisions about their own health care. This included risk assessments and mitigations around decisions made by people about their care.
● Although some mental capacity assessments for areas of people's care such as nutrition had been undertaken, the decisions were not being upheld. For example, one person had been assessed as having capacity around risky food textures. We saw conflicting information about this person's capacity and best interest. This person was not always provided with the food they enjoyed as it had been deemed as 'unsafe'. There was no capacity assessment in place to determine this latest decision.
● The GP had not been involved with capacity assessment around specific questions around choice and capacity, but had documented certain capacity assessments within their GP medical records which were not available to staff.
● There was limited evidence of choice obtained around nutrition and hydration to demonstrate that people consented to the food and type of foods they would like, consequently people were at risk due to poor monitoring and management of food and fluid intake.

People's consent to care and restrictions had not been assessed. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Need for consent.

● The provider had assessed people to see if they were at risk of being deprived of their liberty (DoLS) and had made DoLS applications for a number of people.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care

● Some people received input from a variety of health and social care specialists such as dietitians, occupational therapists and speech and language therapists in response to their specific needs, however we did not always see guidance recorded within people's support plans.

● The provider employed specialised services such as an occupational therapist and a physiotherapist. However, not all people in the service received support. We also heard that these professionals visited once a week, prior to this they were visiting twice a week. It was unclear of the rational as to why therapy had been reduced. One relative felt that this was having a negative impact on their loved ones ability to keep as mobile and independent as possible.

●Staff told us they were not able to support people's rehabilitation therapy exercises as they mostly provided personal care tasks. This resulted in people not receiving effective care. Staff we spoke to felt that specialist services should be increased to 5 days a week to ensure people were receiving effective therapy.

● Relatives of people using the service told us that on one occasion a family member had missed a medical appointment as the service van wasn't ready. We heard that this had been rebooked and attended.

Adapting service, design, decoration to meet people's needs

● Orchard House had been adapted to provide accommodation in one building.

● The communal areas were not always decorated in a homely manner and there were lots of whiteboards with information displayed which gave an institutional feel to the environment. This was echoed by family, staff and visiting professionals.

● The service had adapted gardens which were wheelchair accessible. The gardens needed some maintenance, i.e the raised beds were overgrown with weeds. One person said they enjoyed gardening and hoped to be involved in this over the warmer months. The manager told us there were plans to refurbish the building and replace the flooring.

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 outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with dignity and respect and their independence was not promoted.
- People's experience of care was affected by the high use of agency staff in the home. Although we observed some positive and caring interactions, we also witnessed some staff not interacting at all with people in the service. They sat opposite the person not engaging for long periods of time. This was not dignified or respectful for the person being supported. People's relatives told us "It's not respect if you don't treat people like people. It feels like as long as people have a 1 to 1 that's the only criteria."
- People told us there was a lack of support for people to maintain their independence. One person told us they spent a lot of time sitting in their room as there was nothing to do.
- People's relatives told us they were concerned their loved one appeared unkempt when they visited. One person's relative said "We have to finish off [persons] shave or do it altogether. I'm concerned about [persons] teeth, I'm concerned they are not being brushed properly."
- The service had recently introduced 'downtime' to support people with fatigue. This often-meant family were unable to use the lounge area to visit their loved ones and people were not always able to access therapy. Management reflected on this on agreed to review the effectiveness of this approach.
- We heard that the vehicle used to support people to access the community had limited use due to staff availability. Plans to visit family at their own home had to be made in advance.

The provider failed to ensure people were provided with appropriate person-centred care that met their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives were positive about the kindness of individual staff. Staff we spoke to demonstrated warmth and compassion about the people they cared for.

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

- Some people's care plans included information on the way they would like their support to be provided and the activities they would like to take part in. However, staffing deployment reduced the ability of the service to respect the decisions people had made. For example, decisions about activities people wanted to do.
- For one resident who was unable to verbally communicate, their relative had initially provided the service with a detailed life history of the person, what they liked and disliked in regards to their care. Relatives felt

that this wasn't always acknowledged.

● One person's recently implemented care plan stated that they were 'Particular in [their] care routine and it is essential that staff are aware to minimise challenging behaviours'. We reviewed this person care notes regarding personal care. We saw the following entry "[Person] was difficult, [they] complained and moaned about what staff were doing for [the person]." There was no further information available regarding what this person's preferences were and how to support them. This was discussed with management who said that they would ensure that this was included within their care plan.

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

- People did not always receive personalised care that met their preferences.
- People's care plans were not always updated to reflect people's current needs. Staff were able to tell us attributes and relationships they had built with individuals, however this information was not available to other staff.
- Reviews had not taken place to ensure people's needs and wishes were accurate and up to date so staff could be guided on how to support people.
- Not everyone had documentation in place to enable staff to understand the goals they were working towards and to evidence effective outcomes.
- The provider did not always support people to follow their interests or encourage them to take part in social activities relevant to their interests. There was limited evidence available that the service met people's individual needs in relation to maintaining interests and hobbies important to them. The provider had a vehicle to help people go to activities they chose. However, we heard and saw that the minibus was full of Christmas trees and had not been in use for many months. The main activity recorded in people's records seemed to be walking around the village.
- Relatives of people using the service told us "There's nothing going on, they [residents] do armchair exercises occasionally."
- At the time of inspection there wasn't an activities coordinator employed by the service. Activities were organised by the staffing team. Staff expressed "We don't have the staff. There are activities that people want to do, but if you are short staffed or do not have reliable agency staff you can't do them."
- We heard of one instance where a person was unable to be supported into the community as they 'had been rude'.

The provider failed to ensure people were provided with appropriate person-centred care that met their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 preferred method of communication was not always supported to ensure they had the maximum opportunity to express their preferences and choices. Due to people's support plans not been completed there was limited information on how people communicated their needs to staff.
● One person's recently implemented care plan stated, 'I communicate with my iPad'. There was no further information available about how to communicate and it did not include specific information about what communication tools were to be used to support their understanding or communication needs.
● People whose first language was not English were not always supported to communicate in their preferred way. We overheard one interaction from a member of staff towards a person who was trying to communicate in their own language. There was no evidence of information being translated into other languages, despite people's needs potentially benefitting from this.
● Throughout our inspection visit we saw limited evidence of staff supporting people with their preferred methods of communication to enable their involvement and seek their views. One person was asked if they wanted tea or coffee, they were asked this multiple times, their preferred method of communication was not used to determine their decision. The staff member supporting them said "I will make you a hot drink and if you drink it you drink it, if you don't you don't".

The service did not ensure people received personalised support to meet their communication needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● When end of life care was imminent, care plans had not been updated in line with individual end of life care, treatment and support needs.
● Where appropriate, people had not been supported or involved in developing their end of life care plans to record their wishes and preferences.
● Not all staff had received training in end of life care and some staff were unaware of who was receiving end of life care and what this meant.

The provider failed to ensure people were provided with appropriate person-centred care that met their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● There were no records of concerns and complaints available as we were told there had not been any complaints made.
●We saw evidence of a complaint made by a member of staff to the service. This was not acted upon. Therefore, we were not assured that complaints would be acted upon by the service.

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 outstanding. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Since the last inspection there had been two managers in the service. The service had deteriorated from outstanding to inadequate. The provider failed to ensure there was consistent managerial oversight of the service's systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
- The service did not have a registered manager in place. The provider employed a new manager in November 2022. The manager informed us that they had submitted the relevant documentation to the registration team at the Care Quality Commission. This application had not yet been submitted. The manager reassured us that this would be submitted following inspection.
- We received mixed feedback on the management of the service. We heard that management was forthcoming with ideas and support, taking the time to ensure that staff understood when they asked questions and took a hands-on approach to managing the service. We also heard that there were times people felt that the manager changed their tone when speaking to people which was felt to be inappropriate and that the home felt more institutionalised due to the set 'down time', removal of pictures and the introduction of white boards.
- The system to ensure safe management of medicines was ineffective, as the provider failed to ensure that night staff were trained to administer medicines.
- The provider failed to have systems to monitor the content of risk assessments and care plans. Staff did not have clear guidance from care plans and risk assessments on how to support service users safely. This put people at risk of harm.
- The provider failed to implement an appropriate system to monitor, evaluate and ensure people's needs were met by staff with appropriate knowledge and skills to meet their needs.
- The provider failed to have oversight of records for supervisions, spot checks, and appraisals. We reviewed some supervision records since the new management had been in place, however spot checks and appraisals were not available to review.
- The provider failed to implement effective investigations and outcomes for safe care following a complaint to human resources.
- Audits were not effective in driving service improvement. We reviewed audits that had taken place. These were not always accurate, and they did not identify the shortfalls we found during inspection. We saw that incident records stated that care plans and risk assessments had been updated, however there was no evidence of this.

● Staff meetings did not discuss incidents and the service development plan did not contain dates; therefore, it was unclear how these were being monitored.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Good Governance .

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 failed to notify the appropriate authorities of events and incidents which impacted people. Records showed there had been a delay in reporting a number of safeguarding incidents to the appropriate authority and CQC.

● The lack and delay of investigations following incidents, poor communication, delay in reporting of notifiable incidents and safeguarding concerns indicated the provider was not fully aware of their responsibilities under the duty of candour.

The provider failed to ensure that notifications were submitted in relation to care and treatment provided to service users in carrying on a regulated activity. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Duty of Candour.

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

● Systems were not established to seek feedback. It was not clear how feedback was sought from people and their families as documentation was not available. We were informed that people's views had recently been collected, however people we spoke to told us their views had not been requested.

● A senior staff meeting, and team meeting minutes were reviewed. Minutes did not evidence any follow up actions following these meetings and we could not always see documentation to support information within these meetings, we received mixed feedback about staff view being listened to.

● The provider had been made aware of concerns in the service but action to rectify concerns were ineffective as concerns were identified in multiple areas of the service during this inspection. There was no evidence that the service had implemented support after concerns raised by staff and a quality visit in January 2023 which identified that people's information was missing from people's care plans and risk assessments were not in place.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17(2) e of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

● The manager was transparent and open during the inspection process, they had begun to take action to improve the service since employment, but this was not always documented.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have access to meaningful activities and processes for assessing and reviewing people's needs were not fully effective in ensuring care met people's needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not always have appropriate documentation in place. There was limited evidence that people were given choice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The local authority had not always been aware of safeguarding incidents. Not all staff were trained in safeguarding adults.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role.

Regulated activity	Regulation

Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to ensure that notifications were submitted in relation to care and treatment provided to service users in carrying on a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably supported, skilled, or qualified to carry out care. The service failed to evidence that staff were suitably supported, qualified and skilled.