Windsar Care Limited

Salt Hill Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Salt Hill Care Centre can accommodate up to 53 people (including couples) and provides nursing care, personal care and respite care to older and younger adults living with dementia, physical disabilities, learning disabilities and mental health support. At the time of our visit there were 29 people using the service.

People's experience of using this service and what we found
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. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support:
There was not a high incidence of falls in the service. However, risk assessment processes required further improvement.to protect people from avoidable harm.

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; the policies and systems in the service did not support this practice.

The provider did not always seek or consider partnership working with all specialist health and social care professionals and external agencies. Further work was needed to provide effective care and support to autistic people, people with learning difficulties, people living with dementia and people who were semi-independent.

People and relatives said their family members were safe from abuse and protected from the risk of infection. Staff records confirmed they had received training and they were appropriately inducted and supervised. There were enough staff deployed to provide care and support to people. People's nutrition and hydration needs were met.

Right Care:
The provider did not always refer to nationally recognised guidance when developing care plans for autistic people, people with a learning disability, people living with dementia and people who were semi-independent.

The provider did not work in line with the Accessible Information Standard, to meet the communication needs of autistic people and, people with a learning disability and people whose first language was not

English.

People and relatives described staff as caring, compassionate, thoughtful, and patient.

Care plans were now more person-centred as they provided detailed information about people's life stories and preferences for care. Improvements were made to make it a dementia friendly environment.

Right Culture:
Further improvements were required in relation to the provider's quality assurance systems, around the auditing of administration of medicines, care planning, assessing and managing risks, communication, and obtaining people's consent.

The provider did not always operate effective systems and processes to make sure they assessed and monitored the service against all regulations.

The provider had introduced new quality assurance systems but it was too early for us to determine how effective they were. The management team were working hard to develop a positive and improvement driven culture.

Rating at last inspection and update
The last rating for this service was inadequate (published 11 October 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. This service has been in Special Measures since 10 October 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
The inspection was prompted in part due to concerns received by local authorities about ineffective management and to follow up concerns found at our last inspection of the service. A decision was made for us to inspect and examine those risks.

We found no evidence people were at risk of harm from these concerns. However, we found further improvements were needed in relation to management of medicines, assessing and managing risks, effective care planning, meeting people's communication needs, need for consent and good governance.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, need for consent, safe care and treatment, and good governance.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Salt Hill Care Centre

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors, 1 pharmacist inspector, 1 specialist advisor and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Salt Hill Care Centre 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 a registered manager in post. However, they were not working in this capacity and had not submitted their application to de-register. The provider had recruited a new manager who had applied to become the registered manager.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 5 July 2023 and ended on 22 July 2023. We visited the service on 5 July 2023. An inspector conducted staff telephone interviews on 12 July and 22 July 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. Feedback of concerns about the service was received from local authorities and was included in the planning of this inspection.

During the inspection
We spoke with 8 people, 2 care workers, 2 senior carers, registered manager, operations manager, 2 directors and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked in detail at 10 care plans, 11 medicine administration records, 5 staff recruitment files and the service's staff training matrix. We looked at a variety of records relating to the management of the service, this also included the service's policies and procedures.

Requires Improvement

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 changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection we found the service did not do all that was reasonably practicable to protect people from unavoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 12.

- At our last inspection we found the service had incomplete risk assessments and risk management plans in place where risks were identified for people. During this visit, the provider did not do all that was reasonably practicable to mitigate risks.
- People were not always protected from avoidable harm. A person living with dementia was assessed at high risk of falls. The person had experienced a fall on 25 April 2023 when they were attempting to be seated. Staff were instructed to monitor the person and to conduct 'regular checks when seated'. This instruction placed the person at risk of avoidable harm, as it had no relation to what action staff should take, if the person tried to sit down.
- Another person living with dementia, and who walked with purpose, was also assessed of being high risk of falls. Their falls risk assessment dated 13 June 2023, stated the person was on hourly checks and staff were to closely monitor them and always check their whereabouts. There were no records to show hourly checks were completed and it was not clear how staff would closely monitor the person when they had already been assigned to other care tasks.
- Another person's moving and handling assessment dated 27 June 2023, stated the person could mobilise but was unsteady on their feet, tended to walk backwards, and was at risk of falls when they had chest infections. There were no specific instructions to tell staff what to do when these things happened.
- People could not always be assured the level of risk was assessed accurately. We reviewed the mobility and falls risk assessment for 2 people who were restricted to their bed and chair. Records documented appropriate action had been taken to prevent falls, but staff still assessed them at high risk of falls. This meant the assessment of risk were not always a meaningful exercise for staff and was not always based on people's individual circumstances.

There was not a high incidence of falls in the service. However, our findings from reviewing care records and staff training records identified failing in the risk assessment processes and improvement was needed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● After our inspection, the provider's service improvement plan (SIP) showed staff were booked on falls prevention training facilitated by the local authority.
● Risk assessments had improved in relation to people who were at risk when distressed, malnourished, choking and when they had epileptic seizures.
● People and relatives told us the environment was well maintained and they felt safe.
● A bath with an electronic chair on the ground floor was not in working order and there was no visible signage to reflect this. This would have alerted staff supporting people with personal care, not to use it and prevent any potential harm. We shared this with the manager, who after our visit, sent evidence to show signage was now clearly displayed.
● Window restrictors used to prevent windows from opening to a certain point and hazardous agents were stored safely. Personal emergency evacuation plans (PEEPs) had relevant information to enable staff to evacuate people safely.

Using medicines safely

At our last inspection we found unsafe medicines practices that placed people at potential risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 12.

● Management of medicines had improved but further improvement was required to ensure the proper and safe management of medicines.
● Whilst most people had 1 or more medicines prescribed to be administered as and when required (PRN), person-specific guidance was not always in place. Transcribed guidance on the protocols was not always legible to aid staff when administering PRN. Therefore, we were not assured that staff would consistently assess people's need for PRN medicine administration.
● In our last inspection we saw staff did not consistently record the time, reason and outcome for people receiving PRN medicines. On this occasion, when PRN medicines were administered, staff recorded the time of administration but the reason and outcome for the person receiving the medicine were not always clear. For example,1 person was administered PRN to manage 'agitation', however the daily notes recorded by staff did not state the person was 'agitated' or state any reasons for the administration of PRN. Therefore, we could not be assured that PRNs were being administered as directed by the prescriber.
● People who were prescribed topical medicines had records of where to apply creams and administer eye drops on Topical Medicines Administration records (TMARs). However, the directions transcribed on the TMARs were not always legible and were not always the same as the directions stated by the prescriber on the Medicines Administration Records (MARs). Therefore, we could not be assured that all staff were applying the creams as directed by the prescriber.
● Some people were administered medicines covertly (when medicines are administered in a disguised format). However, 2 people were given administered medicines covertly where the appropriate legal framework had not been fully followed in line with the Mental Capacity Act 2005. Therefore, we could not be assured that medicines would always be administered in the best interest of people.

We found no evidence people were harmed but there were still some unsafe medicines practices that placed people at potential risk of harm. This is a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff who administered medicines had received formal training and supervision to ensure they were

competent to administer medicines. Since our inspection, nursing staff received and attended further medicines training organised by the NHS and the NHS medicines optimisation team were providing continual support to the service.
● At our last inspection we found medicines requiring refrigeration were not always kept within their recommended temperature range. On this inspection, we found medicines were stored securely, and records demonstrated that the fridge and room temperature where medicines were kept were monitored regularly by staff.

Learning lessons when things go wrong

At our last inspection we found systems did not enable the service to effectively identify and learn when things went wrong. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Some improvements had been made but further improvements were required therefore, the provider continued to be in breach of regulation 17.

● Audits of care records did not identify areas for improvement. Although it was evident that information in the care plans was regularly reviewed, it was not always clear why there were significant changes. For example, a person's waterlow score, which calculates the risk of a pressure ulcer developing, was recorded as 8, 17, 7, 8, 12, 9, 11, and 14 between 2 January 2023 and 11 June 2022 but with no obvious analysis of why this was. This was a missed opportunity to learn and improve in this area of care.
● Medicines audits were conducted monthly to check if medicines were managed safely, however issues we identified were not found as part of the audit. Therefore, we were not confident lessons would always be learnt.

Further improvement is required to ensure quality assurance systems could identify and take action to prevent things going wrong. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● Lessons learnt were documented on individual accident and incident forms and shared with staff to enhance learning and improve practice.
● Monthly analysis of safeguarding and accidents and incidents documented where the incident happened, circumstances, time of day and names of people who were involved. This helped the service determine if there were any emerging patterns and make necessary changes to drive further improvements.

Systems and processes to safeguard people from the risk of abuse

At the last inspection we recommended the provider seek current best practice and national guidance to ensure appropriate action is taken when unexplained injuries happen.

● During this inspection, we found appropriate action was taken when unexplained injuries happened. Accident and incident records showed there was only 1 incident dated 24 February 2023 that concerned a person who had unexplained bruising.
● The incident record showed staff had taken appropriate action and reported this concern to the local authority. A unit manager had completed an investigation to determine what could have caused the injury and appropriate preventative action was put in place to prevent further harm.
● People and relatives said they were safe from abuse, knew who they would speak to if they felt unsafe and

did not have to raise any complaints about their safety. Comments included, "Yes (feels safe), I like it here, they [staff] look after me" and "I just feel safe here."
● The provider's safeguarding policy was last updated on 31 March 2023 and was easily accessible to staff. This provided guidance on what staff should do if they suspected people had been abused. We noted the policy was not updated to accurately reflect the new manager in post.
● Staff were up to date with relevant training and demonstrated a good understanding of how to identify and report abuse.

Staffing and recruitment

At our last inspection we found there was a potential risk of harm because there were insufficient numbers of staff to meet people's care and support needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● People gave mixed feedback about staffing. Comments included, "Oh yes" (there is enough staff), "Personally it was better when there were 3 staff on duty. I think they could do with an extra pair of hands especially in the evenings as they are always rushing about", "Yes I do, they look after me" and "Honestly, no, that's one concern but unfortunately that's the state of health in this country."
● Mixed feedback was also received by staff. We spoke with the manager who recognised more staff were required in some of the units. The provider was in the process of recruiting more staff.
● After our visit, the registered manager sent us updated staff rosters and service user dependency tools. These showed additional permanent staff had been recruited. There were sufficient staff deployed to ensure people's welfare and safety.

At the last inspection we recommended the provider seek current guidance and best practice to ensure all relevant recruitment checks are completed.

● During this inspection, we found the provider had taken appropriate action to ensure safe recruitment was in place. Files showed staff recruitment checks were completed in line with the legislation. All new care staff went through Care certificate training. This essential training for staff new to working in the social care sector.
● Staff had DBS checks prior to commencing work. Disclosure and Barring Service (DBS) checks provide information, including details about convictions and cautions held on the Police National Computer. The report helps employers make safer recruitment decisions. Checks of nurses' registrations and renewals were completed to ensure they were legally entitled to practice.

Preventing and controlling infection
At our last inspection we found unsafe medicines practices that placed people at potential risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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

● People were protected from the risk of infection. Comments from people and relatives included, "Gloves everywhere, masks sometimes and always apron. They [staff] wash hands before they shower me every day"

and "I've seen that personally (staff wearing PPE), I've never had a problem with how they keep [person] safe from infection."

● The environment was generally clean, we observed cleaners working in the service throughout the day. There were several personal protection equipment (PPE) stations throughout the building, which were fully stocked for staff to use when needed.

● Storage facilities had clean linen, such as pillows, sheets and duvets stored on shelves in linen cupboards.

● Cleaners followed the national NHS cleaning code. This requires certain coloured mops, buckets, and clothes to be used for different parts of the building, such as floors, bathrooms and seating.

● Bathrooms, sluice rooms and communal areas were clean and tidy.

● The provider's infection prevention and control policy was up to date and staff were up to date with relevant training.

Requires Improvement

Is the service effective?

Our findings

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

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

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

At our last inspection we found staff did not work consistently to make sure people received person-centred care and support that was appropriate and meet their needs. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Although some improvements had been made, further improvements were required therefore, the provider remains in breach of Regulation 9.

● During this inspection, we found the provider did not always refer to CQC's statutory guidance, Right support, right care, right culture and nationally recognised guidance when developing care plans for autistic people, people with a learning disability, people living with dementia and people who were semi-independent.
● We reviewed 4 dementia care plans and 1 care plan for an autistic person. These did not always document how dementia and autism affected people's everyday living and what symptoms staff should look out for. This would have helped staff get a better understanding of changes in people's behaviour and, enable them to support people to receive prompt support from relevant specialist health professionals.
● Where people who used the service were semi-independent, care plans did not include agreed goals regarding their learning life and social skills.

The care and support needs of people living with dementia, autism and living semi-independent were not always met. This was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● After our inspection, the provider sent us their updated SIP. This showed the provider had recently engaged with a specialist dementia organisation. The aim will be to people living with dementia and to educate staff on how to support effectively support them. Staff had also been booked to attend mental health training organised by the LA for September 2023.
● Care plans were now more person-centred as they provided detailed information about people's life stories and preferences for care. People had activity plans which documented their social interests and hobbies.
● Weekly activity timetables were displayed in communal areas and staff told us activities displayed were

chosen by people. We observed several instances where staff supported people during an activity session (flower arranging) and during the mid-day mealtime. Staff spoke to people in a courteous and respectful manner whilst providing them with the support they needed.
● Activities coordinators had completed relevant training to provide them with the knowledge and skills about how to promote social integration and appropriate stimulation for people living with dementia.

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). 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.

● The provider did not always provide information in an accessible format. We reviewed an autistic person's care plan. There were no visual cues including photographs or symbols which have helped the person know what was likely to happen during the day and who would be supporting them.
● The person had a hospital passport, which is a document used by autistic people and people with learning disabilities to communicate their needs to nurses, doctors and other health professionals. However, this was just a duplicate of the person's full care plan and was not written in an easy read or pictorial format to aid the person's understanding.
● Where English was not people's first language, care plans did not document how staff should effectively support them. We had observed a person who was involved in an activity session, staff had told us the person did not speak English. It was not clear how involved the person was in the activity or if they understood the conversations or instructions given.
● Later in the day, we observed the person approach a staff member and spoke a long sentence in their language of origin. The staff member placed their arm around the person, shook their head and said, "I'm sorry, I don't understand." The staff member told us, "Sometimes we try to use Google translate but it's very difficult." Although the person's communication care plan stated staff should use different forms of communication tools, this did not consistently happen. This had the potential for causing the person to experience isolation.
● Where people were known to express distress and anxiety, there was no information on how to support them. This would have ensured new or temporary staff could reduce the likelihood of people having a difficult day by following how best to support them. This was information was lacking in all care plans viewed.

People's communication needs were not always met. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● The service's complaints policy was translated into various languages to enable people to raise concerns.

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

At our last inspection we found there was no pro-active plan in place to form working partnerships with the aim of improving the lives of people with poor mobility and people's care needs were not regularly reviewed. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

● The provider did not always seek or consider partnership working with all specialist health and social care professionals and external agencies. During this inspection, we reviewed the care records of 5 people who were assessed as medium to high risk of falls and had experienced repeated falls, as found at our last inspection, physiotherapy input was not always sought or considered.
● Where people were assessed as not having capacity to make specific decisions and who had no legal representatives to support them, staff did not always take pro-active action to contact Independent Mental Capacity Advocates (IMCAs) to advocate for them.
● Staff had not involved a learning disability specialist when planning the care and support for an autistic person.
● The service provides care to people, some of whom have complex health care needs. However, a multi-disciplinary approach to meeting those needs was not always considered. For example, people living dementia, mental health conditions and learning disabilities and, those who were susceptible to falls, were not referred to the various multidisciplinary support available. This would enhance the service's ability to provide individualised and effective care to support to these groups of people.

There were no consistent working partnerships with the aim of improving the lives of autistic people, people with learning disabilities, living with dementia, complex health needs and, with poor mobility. This was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● A GP visited regularly, and staff could record in advance of the GP rounds any people that needed assessment. Out of hours calls to healthcare professionals were also used by staff.
● Healthcare professionals such as dentists and podiatrists, were used to ensure people maintained a healthy lifestyle.

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

At our last inspection we found the registered person failed to ensure consent was correctly established in accordance with the Mental Capacity Act 2005.

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

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.

At our last inspection, we found people who were not able to make specific decisions were not always protected. This was because consent was not always obtained, documented, and reviewed in line with the

law. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

● During this inspection, we found nursing and senior staff's work practice relating to the MCA, was still not line with the MCA and its Code of Practice.
● Staff had completed mental capacity assessments and recorded best interests decisions. However, no changes were made from our last inspection as multiple decisions were considered all at one time; the MCA Code of Practice requires the process to be both decision and time specific.
● Some people who were assessed as lacking capacity to make decisions about their medicines, had their medicines given covertly (in food or drinks). Best interests decisions records did not show involvement from the prescriber of the medicines [pharmacist]. Altering the characteristic of medicines may change people's response to the medicine and the pharmacist would be able to determine if this decision would be appropriate.
● Care records for an autistic person stated at certain times they would become distressed which resulted in them putting themselves or others at risk of harm. The person was prescribed medicine which was to be administered when the person became distressed. There was no record of a mental capacity assessment to show staff had sought input from a relevant specialist health care professional to look at the least restrictive options before arriving at this decision.

The provider did not always work in accordance with the Mental Capacity Act 2005. This was a continued breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● After our inspection, the provider's updated SIP showed arrangements had been made for to attend MCA training organised by the local authority.
●There was a list of people who had applications for existing or lapsed DoLS authorisations in place. The provider had records to show the status of these applications.
● Care records showed if people had legally appointed attorneys for health and welfare, finance, or both and if there was a Court of Protection appointed attorney. This ensured the service knew who had legal powers to act on people's behalf.

Staff support: induction, training, skills and experience

At our last inspection we found the service did not always ensure staff were suitably qualified, skilled and competent to meet people's care and support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● People received care and support from staff who were suitably qualified, skilled, and competent to meet their needs.
● People and relatives felt staff were trained. Comments included, "They [staff] do go on training and it helps them. If I need anything, they do it for me because they are trained" and "Definitely [think staff are trained], I'd say the way they care for them [people], and the love and the care which is a good balance. They have so much patience. I can see the professionalism; I have a short switch and I couldn't have the patience

they have."
● Staff had completed essential and specialist training. This included learning disability, fall awareness, dementia and challenging behaviours, epilepsy, and autism. Training was a combination of practical and on-line training.
● Staff who administered medicines received training as well as competency checks every 6 months. Staff observations were completed when shortfalls occurred to ensure learning following errors.
● Staff were supported with 2 monthly supervisions. The content of the supervisions has been changed to be role specific and more meaningful.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection we made a recommendation for the service to seek current guidance and best practice in relation to providing snacks.
● During this inspection, people were offered a variety of nutritious snacks throughout the day and staff would take into consideration when people preferred to eat 'little and often'.
● People and relatives felt their nutritional needs were met by the service. For example, a person commented, "I'm on a diet because I'm putting on weight. They've cut me down, but I get enough. I tell them what I want, I choose chicken, that's my favourite and they know that. I'm happy with the food. For breakfast I have buttered toast. I did have porridge but it's too fattening so now I have Weetabix."
● Staff told us people could ask for anything not on the menu and it will be provided. A staff member commented, "There is 1 person who often requests meals not on the menu and they have their own menu chart created."
● Meals were adapted to meet people's cultural and religious needs and a 3-week rolling menu was displayed showing food that people liked.
●Written feedback was sought post meals by the kitchen staff and was used to make improvements around menu options.

Adapting service, design, decoration to meet people's needs
At our last inspection, the registered person failed to ensure the premises and equipment were adequately adapted, decorated and maintained to ensure people's safety and welfare. This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● At our last inspection, the lower ground floor, a previous water leak which had caused extensive damage to the floor covering. During this inspection, we saw work had been undertaken to resolve the issue with the leak and workmen were in the process of refurbishing the whole of the lower floor.
● The provider redecorated parts of the building to support people who were cognitively impaired. Some corridors had lighting that was not harsh as recommended for people living with dementia. Corridors were painted different colours as were people's doors.
● The doors had name plates and a photograph of the person whose room it was and the memory boxes on the walls outside the rooms, were full of objects to aid memory. A memory sensory room was available for people living with dementia. This helped to safely stimulate all five sensors and created a calm environment.

● Kitchenettes on all 4 floors were changed and countertops and cupboards were in a good standard.
● Doors were required to be locked to prevent avoidable harm to people, where appropriate. The service was clean, and equipment and fixtures were in a good repair.
● Signage and suitable items were attached to the walls for people living with dementia. This included items

for people to touch and feel or interact with. These were maintained to a suitable standard.
● There was a wheelchair accessible lift between floors, and a ramp at the front of the building for people with mobility impairments.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection this key question was rated inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

At our last inspection, we found people received care and support from a service that did not always promote an open and empowering environment for people with a learning disability, living with dementia or people living in the service who were semi-dependent. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Whilst improvements had been made, we found care and support still did not always reflect current evidence-based guidance, standards, and best practice to meet the needs of people with a learning disability, living with dementia and people living in the service who were semi-dependent.
- This was identified when we reviewed the medicines charts, care plans, risk assessments, daily communication log, and consent documentation.

The provider did not always operate effective systems and processes to make sure they assessed and monitored the service against all regulations. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Management was visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.
- Staff felt respected, supported, and valued by the management team who were working hard to develop a positive and improvement driven culture.

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

At our last inspection, we found the provider failed to monitor progress against plans to improve the quality and safety of the service and records relating to care and the management of the service, were not fit for purpose. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

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

● The provider's system for auditing the service did not always identify when quality and safety was being compromised. For example, the manager had sent us care plan audits completed in the same format we had found at our last inspection. These were ineffective as they still failed to identify the issues we had found. Whilst some improvements had been made, we found audits had not identified the concerns we had found during this inspection.
● Analysis of audits did not always help the provider to improve the quality of the service. The provider's SIP recently updated in July 2023, failed to capture all the issues found at our last inspection and during this visit. For example, risk assessments and risk management plans were not completed in line with national guidance and best practice was not identified in the provider's SIP.
● Some records relating to care and the management of the service still were illegible and not fully completed. Care plans did not provide enough information to support people, falls risk assessments had contradictory information about level of risks and pre-admission assessments were not uploaded on to people's electronic care records.
● Activity care plans did not record whether people's social interest needs were met. Best interests decision records did not show what people, those who legally represented them and, health professionals had discussed in the meetings. Medicine records were not always legible and written directions were not in line with prescribers instructions.
● There were no systems in place to gauge staff's understanding of the training received to ensure learning had been embedded.

The provider failed to ensure improvement plans captured all concerns, audits were ineffective in identifying shortfalls and records relating to care and the management of the service, were not consistently fit for purpose. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection, the provider had hired a consultancy firm. Progress to address the concerns found at our last inspection was slow due to changes in the consultancy firm used. However, the consultant had developed a plan of action, in conjunction with local authority commissioners, to address these concerns. New quality assurance systems had been introduced but it was too early for us to determine how effective they were.
● People and relatives felt the service was well-led and described staff as caring, compassionate, thoughtful, and patient. Staff felt the culture of the home was changing to a more open, empowering and supportive environment.
● The provider had addressed concerns found at our last inspection relating to, safeguarding people from abuse, preventing and controlling infection, premises and equipment, supporting staff, supporting people to eat and drink and duty of candour.

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

At our last inspection, we recommended the provider ensure their work practices are line with the Duty of Candour Policy and Procedure.

● Where there were notifiable safety incidents, records showed the provider had worked in line with legislation to ensure they acted in a timely manner to ensure letters were sent to people and their relatives, when thing went wrong.
● The provider submitted statutory notifications to inform us of notifiable incidents that happened in the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always refer to nationally recognised guidance when developing care plans for autistic people, people with a learning disability, people living with dementia and people who were semi-independent. The provider did not always seek or consider partnership working with all specialist health and social care professionals and external agencies. This was in relation to improving the lives of autistic people, people with learning disabilities, living with dementia, complex health needs and, with poor mobility. People's communication needs were not always met. Reg (9) (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not always work in accordance with the Mental Capacity Act 2005 and its Code of Practice. Reg (11) (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Treatment of disease, disorder or injury	There was not a high incidence of falls in the service. However, our findings from reviewing care records and staff training records identified failing in the risk assessment processes and improvement was needed. Reg. (12) (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did always operate effective systems and processes to make sure they assessed and monitored the service against all regulations. The provider failed to ensure improvement plans captured all concerns, audits were effective in identifying shortfalls and records relating to care and the management of the service, were not consistently fit for purpose. Work is required to ensure quality assurance systems could identify and take action to prevent things going wrong. Reg (17) (1).