Tributary Ltd

Asquith Hall

Inspection report

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15 June 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Asquith Hall is a residential care home providing personal and nursing care to up to 53 people. The service provides support to people living with dementia and people with mental health needs. At the time of our inspection there were 36 people using the service.

The service is purpose built with accommodation provided in two separate wings; Willow on the ground floor and Meadow upstairs. Each wing has its own facilities including lounge and dining areas.

People's experience of using this service and what we found
People were not safe. People were at risk of harm because the provider did not always identify or mitigate risks. This included risks relating to people's health and care needs as well as risks from other people they lived with. Medicines were not managed safely. Accidents and incidents were not always appropriately recorded and staff did not always follow safe practice when using restraint.

Care was not always person-centred and care records did not fully reflect people's needs. People were not always treated with dignity and respect, and their experience of care varied. Some staff interacted very little with people and other staff were very caring and skilled when diffusing potential risky situations. Some activities were taking place and the registered manager had plans to further develop these when a second activity worker finished their induction.

Staff did not receive the training and formal support they needed for their roles. Staff did not always have time to be flexible and respond to changing needs.

The service supported people to access appropriate healthcare support and a team of specialists employed by the provider were involved in people's care. The service worked in partnership with health and social care professionals. Other agencies told us the service was engaging.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service had made some improvements but they were still not always identifying, capturing and managing quality and safety. The service carried out a range of checks, but these did not identify some key issues and secure improvements. The service had improved systems for preventing and controlling infection and communication. We observed several team meetings; these were well attended and informative.

The registered manager and provider took some action during and after the inspection although not all actions were completed as agreed.

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

Rating at last inspection and update.
The last rating for this service was inadequate (published 25 October 2021).

At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We found the provider had not taken appropriate action to mitigate these.

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

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, safeguarding people from abuse, person-centred care, dignity and respect and good governance at this inspection.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Asquith Hall

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 five inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Asquith Hall 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. [Care home name] is a care home [with/without] nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 10 May 2022 and ended on 15 June 2022. On 10 May 2022 five inspectors which included two medicine inspectors, and an Expert by Experience visited

the service, on 17 May 2022 two inspectors visited, and on 15 June 2022 three inspectors visited which included one medicine inspector.

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, Healthwatch and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our 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.

During the inspection
We observed how people were being cared for to help us understand the experience of people who could not tell us about their experience. We spoke with three people who used the service, 14 members of staff including the provider, registered manager, nurses, senior care workers, care workers and chef.

We reviewed a range of records. This included 13 people's care records and multiple people's medicine records. We looked at three staff recruitment files. A variety of records relating to the management of the service were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to have robust risk management processes, which meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people were not always assessed and managed safely.
- At the last inspection we reported where risks had been identified, actions had not been taken to ensure people's safety. For example, sensor equipment to help mitigate risks was not always switched on. At this inspection we found this was still happening.
- At the last inspection we reported that people with limited mobility were not supported safely by staff to move and transfer from one chair to another. At this inspection we saw unsafe moving and handling techniques. For example, staff did not follow care plan guidance or use recommended aids when encouraging one person to stand from their wheelchair.
- Staff did not always use equipment safely, for example, one person's foot plates on their wheelchair were folded up but not back when stationary, this may have caused injury to the person and other people.
- Care records did not always evidence people were receiving safe care. For example, one person had multiple pressure sores, but it was not clear how these were being managed. Two people had made decisions not to follow medical advice but there was a lack of information to show the risks had been fully explained. Following the site visit, the registered manager confirmed action was taken to address this with both individuals.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and operations manager responded to the inspection findings and sent information to show they were taking action. However, when we carried out the third site visit, we found some actions had not been implemented.

- Since our last inspection, the service had improved how they managed some areas of risk. For example, the provider had introduced a safer system for restricting window openings above ground floor level.

● Regular checks of the building were carried out to help keep people safe.

Learning lessons when things go wrong

At our last inspection the provider had failed to have robust risk management processes, which meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The system for learning lessons was not reliable or robust. The provider did not have an accurate overview of what was happening in the service because accidents and incidents were not always recorded. For example, a member of staff was assaulted and staff used restraint to stop the person causing further injury. No incident form was completed, and the registered manager was unaware of what had happened.
● At the last inspection we reported that accidents and incidents were not reported, investigated or dealt with appropriately. Some incident reports had referred to the use of restraint, but there was insufficient detail to determine whether these restrictive interventions were appropriate in each situation. At this inspection we found similar issues.
● At the last inspection we reported that accident and incident analysis reports identified lessons to be learned and actions to be taken to prevent a recurrence. However, we found these actions had not always been implemented. At this inspection we found similar issues. For example, recurring themes were recorded for January, February, March and April 2022 which indicated lessons were not always learnt.

The lack of effective risk management processes meant people were not protected from harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The service did not always protect people from the risk of harm from others. One person had been physically assaulted by other people they lived with on 12 separate occasions in 2022. The person's care plan made no reference to their vulnerability or provided any information about how the person was being protected from further incidents.
● The provider had submitted safeguarding notifications to CQC and referred incidents to the local safeguarding team but not every event was reported. For example, a safeguarding incident occurred on 6 June 2022 but was not shared with CQC or the local safeguarding team.

Safeguarding procedures did not protect people from avoidable harm and abuse. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the site visits CQC shared concerns with the local safeguarding authority.
● Staff understood they had to report safeguarding concerns and confirmed they would always do this.

Staffing and recruitment
● The provider used a tool to calculate staffing levels however, we found staff did not always have time to be flexible and respond to changing needs.
● Call bells were not always answered promptly. For example, we observed staff did not respond for 13

minutes and on other occasions five minutes and six minutes.
● People had to sometimes wait for staff before they were supported with meals and drinks.
● Some staff raised concerns about staffing levels and told us weekends were especially a concern. One staff said, "There's not enough staff and it also depends what staff are on. We have a lot of agency."
● Applicants were not routinely asked to explain reasons for leaving previous employment. The registered manager added an additional section to their application form as soon as we brought this to their attention. One staff file did not have a recent photograph which the registered manager agreed to follow up.
● Recruitment checks were completed prior to employment. Staff files contained references to confirm suitability to the role, proof of identity and a Disclosure and Barring Service (DBS) reference number. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were not managed safely. Quantities of remaining medicines did not always match the records of doses administered, so we could not be assured medicines were administered as prescribed.
● Information to support staff to safely administer medicines covertly, hidden in food or drink, was not always available. This meant there was a risk people might be given their medicines in a way that could affect the way they work.
● Medication administration records for medicines not administered daily, for example every three months, did not always contain information to make sure staff knew the required dose of medicine or when the next dose was due.
● Information regarding people's allergies was not always recorded on relevant documentation, so there was a risk people might be given medicines which they have previously reacted to.
● When changes to medicines were made these were not always acted upon, this meant that one person did not receive the prescribed medicine at the correct dose.
●The time a medicine was administered was not documented for time sensitive medicines, so, for example staff could not be assured that the required four-hour time interval between paracetamol doses had been observed.

Medicine management systems were not always safe and placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely and securely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Visiting was taking place in accordance with the current government guidance.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received the support, training and supervision necessary for them to carry out their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Staff were not fully equipped to meet the needs of people using the service. The provider's website described the service as providing specialist care to individuals with dementia, complex behaviours that may challenge, and mental and physical health issues. However, training did not routinely cover all the key areas. For example, mental health was not included.
● Staff did not receive up to date safety intervention training which included the use of restraint to prevent people harming themselves or others. The provider's 'reducing physical intervention policy and procedure' policy stated knowledge and practice would be reviewed on an annual basis as an absolute minimum. However, the training matrix showed 11 staff had not completed the training and 31 staff had not received refresher training within the last 12 months.
● The provider had guidance around supporting staff after restraint was used. However, this was not followed. For example, an 'individual staff post incident support checklist' was available but not used. The registered manager said they did not have a format for debriefs.
● Since the last inspection, support for staff had improved but not everyone was receiving formal supervision. The provider's supervision matrix showed some staff had not received a supervision session in 2022. Staff feedback about the frequency of supervision was mixed. One member of staff said they had, "Regular supervision every three months." But another member of staff said, "I have only had one in the last 12 months."

Staff did not receive the training and supervision necessary for them to carry out their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received basic training, which was relevant to their role, such as infection prevention and control and fire safety.

● Staff told us they felt supported by the management team. One member of staff said, "I feel ok to approach [name of registered manager], she is friendly, I can go and knock." Another member of staff said, "[Name of registered manager] is my go-to person and is really approachable."

Supporting people to eat and drink enough to maintain a balanced diet
● The service did not ensure people had enough to drink throughout the day. We observed, in one unit, two people drank very little, but staff recorded incorrectly they had plenty to drink. We also saw fluid intake charts with large gaps.
● People were not always offered drinks with their meals. For example, in one unit, during breakfast people were offered a selection of cereals, toast and cooked breakfast but no drink. This had been addressed when we carried out our third site visit. In another unit we observed during each site visit people were offered drinks with their meals and encouraged to drink throughout the day.

Systems were not robust enough to demonstrate people's hydration was effectively managed. This placed people at risk of harm. This was a breach of regulation 14 (Meeting people's nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's nutritional needs were met. Catering staff had information, so they understood how to meet people's specialist dietary needs.
● People were given a choice of meal and mealtimes were not rushed. Food taken to people in their rooms was covered and taken on a tray. One person had a soft diet which was nicely presented.

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

● Where people lacked the capacity to make their own choices and decisions, capacity assessments and best interest decisions were completed. However, people had acoustic (sound detecting) sensors in their room but some did not have supporting documentation to show the MCA legal framework was followed. The registered manager had started to address this, which included speaking with the DoLS team and reviewing people's care records.
● Systems were in place to monitor DoLS applications.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service supported people to access appropriate healthcare support.
● The provider had a team of specialists who were involved in people's care. They completed regular assessments and offered support and guidance around people's needs.

● People's care records confirmed the involvement of other professionals such as the GP.
● Information about promoting good oral care was displayed in the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs were assessed prior to them moving into the service. The information gathered was used to develop care plans and risk assessments.

Adapting service, design, decoration to meet people's needs
● People's bedrooms were comfortably furnished and personalised. Everyone had en-suite facilities.
● The service was purpose-built and each unit had two separate communal areas although these were not always used. For example, in one unit, only one lounge/dining area was in use and there was not enough space for everyone to eat at the two tables. The provider explained they had a refurbishment plan and would be creating smaller units to make the environment more compatible to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection the provider had failed to ensure people were treated by staff with compassion, dignity and respect. This was a breach of regulation 10 (Dignity and respect) 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 10.

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

- People's experience around how well they were treated and supported varied. This was reported at the last inspection and again at this inspection. We saw some very kind and caring practices but also saw poor care.
- Some staff were seen placing food and drink in front of people without any interaction. One member of staff stood at the back of a person's chair and moved their headrest without any communication. Some staff were seen putting clothes protectors on people without asking or explaining.
- People did not always receive appropriate support at mealtimes. One person had large boiled potatoes with their meal but was only given a spoon; they were unable to cut the potatoes and did not eat them.
- Staff were not always respectful when speaking about people. One member of staff described a person as a 'spitter' and said to keep away. Staff assisted one person into the lounge/dining area in their wheelchair and shouted to other staff, "Where do you want me to put her?" This was not said in a respectful manner.
- Care was not always personalised. At the last inspection we raised concerns about people's footwear. People's care plans stated they should be wearing appropriate footwear to help their mobility and reduce the risk of falls but many had no footwear and wore only socks. At this inspection the provider told us they had taken action to address this by purchasing non-slip socks. However, we saw nearly everyone was wearing identical socks and no other footwear. This is institutionalised practice.
- People were sometimes incontinent and had wet clothing but staff did not ask or encourage people to use the toilet. For example, over a three-hour period. in one communal area, staff only supported one person with personal care and this was because they had been incontinent and their clothing had to be changed. One member staff told us in relation to continence care, "Staff leave it until people need it, they don't check or ask and then see they needed it."

People were not treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People sometimes received compassionate care. Some staff were observed treating people with kindness and consideration. For example, one member of staff brought a person a bowl of porridge and noticed they were asleep so took it away, when the person woke 15 mins later they were given a fresh bowl.
● Staff knew people well and used this knowledge to chat with people about their families and interests.
● Staff were skilled at diffusing potential distressed presentations and anticipating people's needs. For example, one member of staff observed a person was getting upset and suggested to another member of staff to step back.

Supporting people to express their views and be involved in making decisions about their care
● Care plans provided information to support people's preferences. For example, favourite foods were clearly recorded. One person's eating and drinking care plan stated they liked pancakes, which we saw were offered at breakfast.
● We saw examples where staff encouraged people to make day to day decisions such as choosing what to do and eat. A member of staff was seen offering a person different drinks and checking their tea was sweet enough. The member of staff listened carefully to the person's responses and offered alternatives.
● Relatives had been involved in people's care and consulted about certain events, such as health changes and the person's future wishes if they became unwell or died.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

At our last inspection the provider had failed to ensure people were receiving person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Care was not always planned and delivered in a person-centred way.
- The service had installed acoustic sensors in people's rooms and the nominated individual explained how the system could provide a benefit for people, such as, reducing disruption to sleep. However, people's care plans did not explain why the system was being used for them.
- Care plans did not always guide staff on people's current care needs. We found conflicting information about people's current needs. For example, one person's daily records showed they had experienced numerous incontinent episodes dating back to April 2022, yet their care plans and risk assessments stated they were continent. One part of the care records stated the person preferred male staff to support with personal care, yet another section stated they preferred female staff.
- Wound care plans did not always include treatment details such as dressings to be used or how frequently they should be changed.
- Staff told us some people required three or more staff to provide personal care at times due to the person becoming distressed. However, care records did not always show when this level of staffing had been required.

Care and support was not appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Activities on both units were limited. In one unit we saw some people sat for long periods with little stimulation.
- One person was funded for two hours per day one-to-one support for social interaction. Records we reviewed showed this was not provided.
- Another person's authorised DoLS stated they should be given opportunities to go out of the home for walks or activities they may enjoy. However, daily records did not evidence this was being consistently met. There were no entries relating to activities between 29 April 2022 and 7 May 2022. They had visited the park on 11 and 13 May 2022.

Care and support was not always appropriate to meet people's social needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our site visits we saw some people went out for a walk which included going for a picnic in the park and dog walking. One person was colouring, another person engaged in a game with staff. Daily newspapers were available and we saw people reading these and watching the television.
● Some people had been out for a meal a few days before the site visit. One person told us they really enjoyed this. Another person, who stayed in their room, told us the activity workers often went in to chat with them and they enjoyed the interaction.
● The registered manager told us they were further developing opportunities for people to engage in more social and community activities once a second activity worker finished their induction. Plans were in place to increase activity workers from five to seven days a week.

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.

● Systems were in place to meet people's communication needs. People had communication care plans which identified how their communication needs should be met.

Improving care quality in response to complaints or concerns
● Systems were in place to manage complaints including a formal complaint's process.
● The registered manager confirmed they had not received any complaints in 2022.

End of life care and support
● The service followed a gold standard framework for advanced end of life care, which ensured everyone relevant including other professionals was involved. Staff were familiar with the end of life care programme.

● People's preferences, choices and decisions about end of life care were sometimes clearly recorded but not always. The service had contacted some people's family to help support the process.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained 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.

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

At our last inspection the provider's systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there was evidence actions had been taken to improve some of their systems and processes. However, not enough improvement had been made and the provider was still in breach of regulation.

● Governance processes were not effective. This is the second inspection where the service has been rated inadequate overall and it remains in special measures.
● At this inspection we found the service continued to be in breach of some of the same regulations including managing risks to people, treating people with dignity and respect, governance and staffing arrangements. The service had also deteriorated in how medicines were managed and safeguarding people from abuse. This demonstrates the provider's governance systems and processes did not ensure people received safe, quality care and support.
● Record keeping was not consistent and reliable. For example, incidents were not always appropriately recorded.
● Systems used did not always support safe practices. For example, the provider's recruitment application forms did not ask candidates for details of reasons for leaving previous employment even though this is an important part of a safe recruitment process. Records for recording incidents of restraint did not give the author an opportunity to record details of debriefs. These shortfalls had not been picked up through the provider's governance arrangements.
● Systems for identifying, capturing and managing quality and safety were not always effective. The service carried out a range of checks such as a monthly accident and incident analysis, but these did not include some key events.

Systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● The service had made some improvements since the last inspection. For example, around preventing infection. Communication systems had improved. One member of staff said, "Staff morale has improved. We have really good teamwork." The registered manager introduced better systems to help ensure staff were kept up to date, which included daily flash meetings and weekly emails. We observed several handovers and a flash meeting; these were well attended and effective.
● Some systems for identifying, capturing and managing quality and safety were effective. The provider and registered manager carried out some checks and audits which were effective. For example, they completed building and fire safety checks, monitored authorised DoLS and complaints.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The service used acoustic monitoring sensors which were installed in people's rooms but the approach used by the provider was not person-centred and did not mitigate some risks. The system was only used between 8pm and 8am even though people were often in their room during the day. Staff working during the day explained they had not received training so could not access the system.
● The provider did not have up to date assessments for the use of sensors and CCTV, which is a legal requirement. They addressed this when we brought it to their attention.
● Systems were not effective for managing risks to people and ensuring people's human rights were protected. Staff used restraint to prevent people harming themselves or others, but this did not always follow safe practice or follow the provider's procedure. The provider did not have a clear overview how often restraint was used.

Systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The registered manager was visible in the service. Staff feedback about the registered manager was consistently positive. Staff told us they were friendly, approachable and welcomed ideas.
● Staff felt listened to and attended regular meetings. Staff said team meetings were informative and an opportunity to speak out.
● The service worked in partnership with health and social care professionals. Other agencies told us the service was engaging. One agency told us the provider was proactive when submitting information and would often send supporting documentation.