Fulfilled Living Limited

Jabulani

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Jabulani is a residential care home providing accommodation and personal care for people with learning disabilities, physical disability and sensory impairment. The service is one adapted building with nine en-suite bathrooms, there is a lift which allows access between the ground and first floors.

The service is bigger than most domestic style properties. It was registered for the support of up to 11 people. Ten people were living there at the time of the inspection. This is larger than current best practice guidance.

The service did not apply the principles and values of Registering the Right Support and other best practice guidance. These were designed to ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

People's experience of using this service and what we found

Practice at the service placed people at risk of avoidable harm. Bathing facilities were not fit for purpose to safely meet the needs of some of the people living there. The physical environment was not decorated or adapted to a consistent standard to meet the needs of people living with physical disability.

Risks to people's safety were not always assessed, mitigated or managed. Risk assessments weren't always in place. Some risk assessments were old and had not been reviewed in line with people's changing needs.

The provider did not have a credible statement of vision and values. Roles, responsibilities and accountability arrangements were not clear. There were a lack of governance and auditing systems and processes.

Medicine documentation was not always clear. Some people's medicine administration records were missing or out of date.

There was limited use of systems to record and report safety concerns, near misses, accidents or incidents.

Safeguarding referrals were not always given sufficient priority. Some incidents had not been referred to the local authority safeguarding team.

There were enough staff, however they were not always deployed effectively to safely carry out their role. For example, there were no team leaders on night shifts which meant staff needed to call an on-call member of staff if someone required medicine administration.

People were not supported to have maximum choice and control of their lives and staff did not support

them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The physical environment was not decorated or adapted to a consistent standard to meet the needs of people living with physical disability.

People's privacy and dignity were not always respected. There was a lack of systems to identify and therefore protect people against lack of privacy and dignity.

People were not always supported to express their views about their own care. There were times when this had been done in a way that the person was unable to engage with.

People's equal and diverse needs and preferences were not always documented or explored. Although people were not discouraged from expressing their individuality.

Care planning was not robust enough to empower staff to ensure people had choice and control.

Information was not always provided in a way that people could understand.

Staff were kind and caring, we saw pleasant interactions and that people appeared to enjoy the company of the staff during the inspection.

Infection prevention and control procedures were in place and the home was clean and free from malodours.

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 Good (published June 2018)

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, documentation, staff training and managerial support provided to staff. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the full report.

After the inspection, in response to the concerns we raised, the provider contacted an occupational therapist to review the safety of the bathing facilities for some people living there. The occupational therapist confirmed that people were not safely assisted to bathe and the facilities were not fit for purpose. The provider told us they adopted the recommendations made, implemented short term measures to assist people to bathe safely and would then address the long-term plans to improve facilities at the service.

Enforcement
We have identified breaches in relation to person-centred care, dignity and respect, the need for consent, safeguarding people from abuse and improper treatment, the premises and equipment and good

governance at this inspection.

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

Since the last inspection we recognised that the provider had failed to notify us of certain incidents. This was a breach of regulation. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Jabulani

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 Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Jabulani is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Although a manager was registered with CQC, they were no longer employed by the service. A 'home manager' had recently returned to the service after some absence and a new 'manager' had been appointed. They had started their role nine days before the inspection, their application to register as manager with CQC was in progress.

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 reviewed information from our on-going monitoring, such as notifications the provider is legally required to send us as and when certain incidents happen.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three relatives about their experience of the care provided. We spoke with eight members of staff including the manager, senior support workers and support workers. We spoke with one person who lived at the service, other people who live there were unable to speak to us, therefore we spoke with their relatives and one independent advocate.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies relating to the running of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Bathing facilities at the service placed people at risk of avoidable harm. People with significant disabilities were assisted to bathe by being suspended in a hoist sling in a normal domestic bath. Staff we spoke with told us that assisting people to bathe in this way did not feel safe. Not every person who required this assistance had a risk assessment for bathing. For those that did, the assessment was not recent, and risks had not been explored.
- Health care professional assessment had not been sought to advise the provider if the bathing facilities were fit for purpose. We requested that this be urgently assessed by an occupational therapist. This was done after the inspection.
- Risks to people's safety were not always assessed, mitigated or managed. For example, people who required the use of bed rails were provided with bumpers to mitigate the risk of becoming trapped in the bed rails. However, the bumpers were shorter than the bed rail and left a significant section of bed rail exposed. Therefore, the risk of entrapment in the bed rails was still present.
- Where people had significant physical disability, there was no guidance for staff about how to safely and effectively administer first aid in the event of a choking incident.
- Relatives gave mixed feedback about the safety of the care provided. One relative said, "I don't always feel that [name] is safe." Another relative said, "They are very risk aware, I am reassured that [name] is safe and well cared for."
- Where people had lost or gained weight, there was no system in place for this to be monitored or referred to relevant health care professionals. One person had lost a significant amount of weight between March and April 2019. The reasons for this had not been explored, they had not been referred to a healthcare professional and they had not been weighed again since. This placed people at risk of potential illnesses not being identified.

Using medicines safely

- People were at risk because the service was not always clear about its roles and responsibilities in relation to the receipt, storage, administration, recording and disposal of medicines. There was a lack of, and some unclear documentation about medicines. For example, one person required a medicine that instructed staff to use, "as directed." There were no directions available for staff to follow.
- Staff were not provided with effective guidance about the administration of topical creams or medicine patches. Some people's medication administration records (MAR) were out of date.
- People didn't always have a list of their medical history and allergies in their medicine files. This meant staff were not always aware of people's allergies before administering medicine which put them at risk of avoidable harm.

Learning lessons when things go wrong

● There was little evidence of learning from events or action taken to improve safety. There was limited use of systems to record and report safety concerns, near misses, accidents or incidents. Where people had been involved in physical or verbal altercations or had displayed behaviour that could be perceived as challenging, these weren't always investigated to find out the root cause and what steps could be taken to prevent the same thing happening again.

Staffing and recruitment

● The provider did not ensure that staff were able to respond to emergencies or incidents. Staff told us, and the home manager confirmed there were no staff on night shifts who were able to administer medicines to people if they required this. There was a system where the staff could call an on-call senior staff member and they would make their way to the service to assess and administer medicines. However, it had not been explored that the on-call staff might not be able to arrive at the service quickly. Therefore, people were at risk of not receiving their medicines in a timely manner.

● The manager had increased staffing levels in the week before the inspection. They did this because they had identified that staff numbers were too low to safely meet people's needs. Staff told us this had made the service safer and enabled them to manage people's care more effectively.

● One relative expressed a concern that people were not safe in the care of agency staff, "[name] is complex and agency staff don't know how to care for them, this is not safe."

The provider failed to ensure that safe care and treatment was provided to people to prevent harm. Systems and processes in place were not being operated effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They updated the risk assessments and sought urgent advice from an occupational therapist about the bathing facilities.

● Staff supervisions and appraisals had taken place, but they had not been consistent and not completed since the previous registered manager left the service. The manager had identified this was an area for improvement and had plans in place to ensure all staff received regular supervisions and appraisals to develop staff skills and care practices in the future.

● The service was using a high number of agency staff at the time of the inspection. The manager ensured that where possible they used regular agency staff, so they could be confident that the people living there got to know and trust them. The manager explained that this was an interim measure while recruitment was on-going. A number of staff had left the service recently which left them with a number of staff vacancies.

● Staff were safely recruited. All staff were subject to checks with the disclosure and barring service (DBS). References were sought from their previous employer. The manager ensured agency staff had been subject to the same pre-employment checks.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding of vulnerable people was not always given sufficient priority and people were not always protected from abuse and avoidable harm.

● We found examples of physical and verbal altercations between people using the service that had not been referred to the local safeguarding authority. People were denied the opportunity to have incidents investigated by safeguarding professionals. There were missed opportunities to put preventative measures in place. After the inspection we highlighted this to the local authority safeguarding team.

The provider failed to ensure they protected people from abuse and improper treatment. The systems and processes were not effective in protecting people from 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

- The home was clean and free from malodours during the inspection. The provider had an infection prevention and control policy in place.
- Throughout the inspection we saw that staff had access to personal protective equipment, such as disposable gloves and aprons and they used these when necessary.
- Staff we spoke with were knowledgeable about infection prevention and control procedures in line with current best practice guidelines.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The physical environment was not decorated and adapted to an acceptable standard to ensure a safe and secure environment for people. Although bedrooms were personalised and homely, communal areas felt impersonal and did not provide any personal touches. There were limited photographs or other such items to create a person-centred environment. The outside area was small and there was limited availability for people to spend time in the garden.
- There were no adapted bathing facilities suitable for people with significant physical disability. Nine of the 11 bedrooms had en-suite bathrooms, but they were normal domestic bathrooms and not fit for purpose for four people.
- The kitchen was a domestic kitchen with one oven, a four-ring hob and a microwave. Staff told us they faced challenges to cook for up to 11 people with the cooking facilities, especially if there were times when people wanted to eat different things.
- There was one bathroom that was shared, this did not have a working shower. Therefore, the two people who used this were not given the option of a shower instead of a bath.
- There was a sensory room in the building. This had been de-commissioned as the equipment was not maintained. Some people did have access to sensory equipment in their rooms. The sensory room was left as a room that wasn't used. At the time of the inspection there were no definite plans to turn that area into a space that could be enjoyed.

The provider failed to ensure that the equipment and premises used by people was fit for purpose and could be used as intended. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not working in line with the MCA. The provider did not always ensure staff had a full understanding of MCA and DoLS. People didn't always have mental capacity assessments and records of best interest decisions for making certain decisions. Where staff had made decisions on people's behalf, we found evidence that they weren't always the least restrictive option. For example, we saw evidence of people in a communal area being denied the window open as there were people with DoLS in place. This was not the least restrictive option. No consideration had been made to how the window could be open without posing a risk to anyone's safety.
● Documentation that detailed when staff had used physical interventions to stop people behaving in a certain way was not clear. We found one incident where the physical intervention was not an appropriate response. People had not been hurt or harmed by the use of physical interventions, but they were not always done in people's best interest and staff did not follow best practise guidelines to use the least restrict option available to them such as de-escalation techniques.

The provider failed to ensure that care and treatment of was only provided with the consent of the relevant person.This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The service understood that staff required training and development, but this was not up to date or line with best practice guidelines at the time of the inspection.
● Staff we spoke with told us that the training they had received did not always equip them with the skills they needed to do their job effectively. We discussed this with the home manager and manager, they confirmed they had identified concerns with the training provided by the previous registered manager. More training had been sourced and staff were being supported to complete this.
● New staff completed an induction when they began their employment. This included training that the provider deemed mandatory, and a period of shadowing experienced staff.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff prepared food for people. We did not see evidence that people were supported to prepare their own food, or that people were given the opportunity to choose the menu, this would have enhanced their independence skills.
● People enjoyed the food that was provided for them on the day. Staff who supported people to eat did so with kindness and patience. However, we saw one person had finished their food and requested more. Staff told them there wasn't any left. There was no consideration to asking if they would like anything else, or if they wanted to go to the kitchen and choose something different to eat. We discussed this with the home manager.

Staff working with other agencies to provide consistent, effective, timely care

● Information sharing and working with other services had been inconsistent. Safeguarding referrals were not always being made appropriately. There had been a breakdown in communication with the local authority. The home manager and manager discussed with us how they planned to improve this.

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

● The service did not always support people to access health care professionals in a timely manner. As discussed in the safe domain, one person had lost weight, and this had not been identified or referred appropriately.

● People were supported to live healthier lives. We saw one person was supported to engage in physical exercise and was enjoying taking part in a diet group. This person proudly showed us their diet group books and expressed how much they enjoyed this.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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

- People's privacy and dignity were not always respected. During the inspection there was an occasion where from a communal room we could hear a person being assisted with their personal care needs. This compromised both their privacy and dignity. The provider had not implemented systems to ensure people's privacy and dignity was respected and promoted.
- People were not always supported to maintain and develop their own independence. For example, shopping was delivered to the service and staff prepared the meals. We discussed with the manager that some people would be able to assist with shopping and cooking, this would increase their access to the community and encourage their independence.
- There was limited documentation to record what activities people had taken part in. The activities we were told about were mainly around visiting places designed for people with learning disabilities. There was little consideration to ensuring people were supported to be active members of the local community and promote their independence.

The provider failed to ensure people were 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.

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

- People were not always supported to express their views about their care. The service did carry out service user feedback surveys, however, we saw an occasion when this was not presented in a way that the service user could understand. The person was unable to communicate, staff had completed the survey on their behalf. This meant that the survey was not a representation of the person's own feelings.
- People were not always supported to have access to an independent advocate. Independent advocates help people to have a stronger voice and as much control over their own lives as possible. Whilst one person living there did have an independent advocate, we identified another person who may have benefitted from this and the idea had not been explored.
- There were no meetings held for the people to express their opinions on their care. Relatives told us they were welcomed into the service whenever they visited. However, there were no set meetings for relatives to express their views about the care provided.

Ensuring people are well treated and supported; respecting equality and diversity

● People's equal and diverse needs and preferences were not always documented or explored. Although people were not discouraged from expressing their individuality, we could not see evidence of this being promoted or staff being given the information and therefore being empowered to support people.

● Staff were kind and caring and had developed close bonds with the people. One staff member said, "It is a privilege to be part of the lives of the people who live here." People felt comfortable with staff and were confident to tell them if they weren't happy or if they needed anything. We saw staff hold people's hands, and people laugh and joke with staff.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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

● Care planning was not robust enough to empower staff to ensure people had choice and control of the care they received. During the inspection, some people became upset at the amount of noise in the room they were in. We reviewed the care plans and saw people were known to become upset at loud noises. Staff had entered the room, the television was on, they then put some music on and another staff member began playing a musical instrument. At no time had staff asked anyone in the room if they wanted so much music or if anyone would prefer to go elsewhere. This demonstrated that staff did not fully understand the impact that loud noise had on some people.

● Care plans were inconsistent and did not always address the complex health needs of some of the people. They were done on different formats which made it difficult for staff to quickly locate information or keep informed when people's needs changed.

● There wasn't always guidance to inform staff how people's seizures presented and how they should respond.

● Care plan reviews were irregular and not person-centred. We found evidence that care plans were not updated in response to certain incidents. For example, one person had experienced increasing behaviour that may be perceived as challenging, in their care plan review it stated, "No changes." This demonstrated that the review was not effective at assessing the person's changing needs.

● Many of the documents we saw relating to care needs were completed many months previously. When people stayed on a respite basis, their needs were not assessed each time they visited. For example, one person's care documents had been completed in August 2017.

Meeting people's communication needs

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

● The service did not meet the AIS. Information was not always provided in a way that people could understand. People did not have access to their care plans. There were limited pictorial images used around the home to guide people through their daily routines or navigate their way around the building.

The provider failed to ensure that peoples care was being delivered in a person centred way which was

appropriate, met their needs and reflected their preferences. 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.

● The service did not always support people to follow their own interests. People were not always encouraged to take part in meaningful activities that were relevant to their personalities. We found a lack of evidence of people being involved in activities. We discussed this with the home manager who felt that activities did take place but that they were not documented. The lack of documentation meant that it was not possible for anyone to have oversight of the activities and document if people had enjoyed them or not.

● People were not supported to access education or find work in the community. This would have provided an opportunity for people to be active members of the wider community.

● Where activities did happen, they were predominantly in the daytime. Staff rotas showed there were three staff on duty at night, this meant there were not always enough staff to take people out and enable them to enjoy evening activities.

● One relative told us that the service did not do enough to keep people active. They said, "[name] is bored, they need more attention and are not kept busy."

● People living there did not always have access to technology. Assistive technology such as sensor mats were used to keep people safe, but we did not see people having regular and direct access to technology such as computers.

● Relatives we spoke with told us they were welcomed into the service and able to visit whenever they chose. One relative said, "I am always welcomed when I visit."

Improving care quality in response to complaints or concerns

● When people had complained, the service did not always take steps to investigate the complaint or to make changes in response to the complaint. We found evidence of times where complaints had been made and were not documented. The complaints system had been managed inconsistently. We discussed this with the manager who agreed to review the handling of complaints.

We recommended the provider review their policies and procedures around the handling of complaints.

End of life care and support

● The service did not provide care for people at the end of their lives. However, good practice would be to talk to people and relatives or advocates about how they would like to be cared for if they become unwell or approach the end of their lives. This was had not been done. We did not find evidence within people's care documentation that there had been consideration to how people would like to be treated if they were to become seriously ill or approach the end of their lives.

We recommended the provider review their documentation around end of life care and serious illness.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not have a credible statement of vision and values. The service cared for people with a wide range of needs including significant physical disability, complex healthcare needs and people who displayed complex behaviour needs. This made it difficult for staff to fully understand the needs of all the people.
- Parts of the building were not suitable to support people with significant physical disabilities and no measures had been taken to adapt to people's needs or client group being cared for.
- There were low levels of staff satisfaction. CQC had received a number of concerns prior to the inspection about lack of managerial support for staff, staff feeling they weren't listened to and staff being fearful of raising concerns with the previous management due to a blame culture. The provider had not retained oversight of the running of the service while the previous registered manager was in post.
- Engagement with people, staff, public and the local community had been minimal. The manager told us one person had been part of a local gardening project, however, there was no documentation provided to evidence this. Where people were assisted to visit places, they were predominantly for people with learning disabilities and did not create links with the wider community.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Roles, responsibilities and accountability arrangements were not clear within the service. There was a lack of governance and auditing systems and processes in place. For example, medicine audits were inconsistent and had not identified the issues highlighted during our inspection. Accidents and incidents were not reviewed or audited by managers. Managers did not always know when an incident occurred as the system in place relied on staff verbally highlighting this to the manager. We identified occasions where management had not reviewed, and therefore not identified ways to reduce episodes of behaviour that could be perceived as challenging.
- Systems for identifying, capturing and managing organisational risk were ineffective. For example, the bathing facilities were unsafe for some people and the health and safety audits had not identified this.
- Where physical interventions had taken place, the documentation was not thorough, there was no system

in place for managers to review this so did not have oversight of risk or potential risk.
● The service had been through a period of unstable management. The registered manager had left the service in April 2019. Another manager had taken over on a part time basis as an interim measure. A new manager had been recruited and started work at the service nine days before the inspection. Staff told us that during the time of change the service had felt unstable, one staff member said, "This has disrupted the continuity for everyone here."

The provider failed to ensure they had effective systems and processes in place to assess, monitor and improve the quality and safety of the service provided to people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, in response to the concerns we raised, the provider contacted an occupational therapist to review the safety of the bathing facilities for some people living there. The occupational therapist confirmed that people were not safely assisted to bathe and the facilities were not fit for purpose. The provider told us they adopted the recommendations made, implemented short term measures to assist people to bathe safely and would then address the long-term plans to improve facilities at the service.
● Staff spoke positively about the appointment of the new manager and told us they felt confident that the service would improve under their control. Relatives and the local authority spoke highly of the home manager who had taken over on a part-time basis. Comments we received included, "[name] always keeps in touch with me and tells me what's happened, that didn't happen with previous management."
● The manager had implemented a system of staff having lead roles. This was with an aim of staff being clearer about their roles and empowering them to have more responsibility and therefore drive improvements. However, this was very much in the planning stage and the benefits and impact could not be measured.

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 had not submitted notifications to CQC appropriately. We found incidents of verbal and physical altercations between people. The provider has a legal responsibility to notify the CQC about this.

The provider failed to notify the Commission of significant incidents that could cause harm to people. This was a breach of regulation 18 (Notification of Other Incidents) of CQC (Registration) Regulations 2009 (Part 4).

● The providers website stated each bedroom had a ceiling hoist, which was an incorrect reflection of the service and equipment provided. We discussed this with the management team during the inspection who immediately put plans in place to remove false information from the website.
● The provider was required to display the ratings from their most recent inspection on the website and in a prominent position within the service, we found this had been done.
● Relatives we spoke with told us that the manager did contact them to inform them whenever incidents had happened.

Working in partnership with others
● The new manager discussed with us that there were improvements required in the working relationship with the local authority. The manager told us how they planned to improve this and that this was a priority

in their new role.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents the registered person had not notified CQC of incidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and Treatment of Service Users did not meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service Users were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not always fit for purpose

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users

The enforcement action we took:

Completed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to assess, monitor and improve the quality and safety of the service provided

The enforcement action we took:

Completed