Parkcare Homes (No.2) Limited

Spode Close

Inspection report

6-11 Spode Close
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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
Spode Close is a residential care home providing care to four people living with learning disabilities at the time of the inspection. Spode Close is a purpose-built block of self-contained studio style apartments. The service provides accommodation and support for up to seven people with learning disabilities, autistic spectrum disorder, physical disabilities or a combination of these kinds of impairment.

The service did not always apply the principles and values of Registering the Right Support and other best practice guidance. These 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.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support because people using the service did not always receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

People's experience of using this service and what we found
The provider did not have effective systems in place to consistently assess, monitor and improve the quality and safety of the service and ensure regulatory requirements were met.

Medicines were not always managed safely.

Care plans did not always incorporate enough information to make sure measures were in place to protect people and staff from harm. People and staff told us they sometime did not feel safe.

Accidents and incidents were not always investigated or summarised in order to analyse for trends and patterns. Some incidents reports did not include any detail of actions taken to prevent reoccurrence. The provider failed to notify us about some incidents taking place in the service.

There were gaps in health and safety checks.

People were not supported to have maximum choice and control of their lives. Staff did not provide care to people in the least restrictive way possible and in their best interests; the policies and systems in the service did not promote this practice.

People and their relatives told us they knew how to complain. However, relatives of people using the service were not always satisfied with the way their complaints had been actioned upon. Complaints and their outcomes were not always recorded to ensure they were appropriately investigated.

Staff members had access to training organised by the provider. They took part in one to one meetings with management and participated in regular team meetings. However, staff told us that training provided was

not always sufficient to meet people's particular needs.

People were supported to maintain good health, have a balanced diet and access to healthcare services where required.

People were treated with kindness and respect. People's right to privacy and confidentiality was respected.

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 requires improvement (published 2 October 2018). The provider had completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we saw that not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns we received regarding a police incident which led to evacuation of the housing estate. A decision was made for us to inspect and examine risks relating to the incident. This inspection was also carried out to follow up on the action we told the provider to take at the last inspection. We found evidence that the provider still needed to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
At this inspection we identified breaches in relation to the management of medicines, gaps in health and safety checks, service not notifying us about incidents, and lack of effective systems to monitor the service. During this inspection we identified breaches of regulations 9, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also recorded breach of regulation 18 of Care Quality Commission (Registration) Regulations 2009.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Spode Close

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

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was run by a manager who was in process of registering with the Care Quality Commission (CQC).

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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. We reviewed information we had received about the service since the last inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and one relative of a person using the service about their experience of the care provided. We spoke with one member of staff, the deputy manager, and the operations director. We reviewed a range of records. These included three people's care records and two people's 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 were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and compliments and complaints records. We spoke with the local authorities, two professionals who regularly visit the service, three staff members and two relatives of people living at Spode Close.

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 requires improvement. 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; Learning lessons when things go wrong

At our last inspection we found that the provider failed to ensure risks associated with people's care and health and safety were assessed and followed by management plans to mitigate such risks. 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 associated with people's healthcare needs were not always identified and assessed. The information about the risks was not always cross-referenced in care plans and hospital passports. One person was known to display behaviour that may challenge and due to that behaviour was always supported with two members of staff. However, this person's hospital passport was left blank in the section 'what to do if I am anxious'. This would leave hospital staff without any information on how to support the person safely.
- Some people displayed behaviour that may challenge others, but not all of these were managed safely. There was a brief reference to the behaviour that may challenge in one person's 'mental wellbeing' care plan, but this was not reflected in a positive behaviour support (PBS) plan. A PBS plan is a document that examines the reason for a person's behaviour, and explains the help they need before, during and after an incident of behaviour that challenges other people. By not having a PBS plan, staff would not be aware of how to safely support the person. As a result, the person with particular needs would not be given consistent support.
- This person had been seen by a PBS practitioner only once, since they had moved in to the service almost six months before our inspection. There were other care plans that described the support the person needed when they were experiencing high anxiety. However, they lacked precise guidance for staff on what to do when the person's behaviours escalated. Management plans were in place but were not evaluated in terms of effectiveness. This meant the person's anxiety could not be managed consistently and effectively, which affected their well-being and the well-being of other people living at the service.
- The provider did not ensure health and safety risks were assessed and monitored to keep people safe from harm. For example, there were gaps in fire alarm system checks. This meant the provider could not be assured that the fire alarm call points were working satisfactorily. We referred our concerns to fire services.
- There was little evidence of learning from events or actions taken to improve the safety of people living at the home and the staff team. There was limited use of systems to record and report externally safety concerns, accidents or incidents.

● Where accidents or incidents occurred, they were recorded by staff and reviewed by the management team. Where lessons could be learnt to reduce the likelihood of a reoccurrence, the management team did not always ensure staff practice was altered to achieve this. For example, as a result of one person's behavioural incident a member of agency staff had to be admitted to hospital and police had to intervene in the service. We remained unnotified about the incident and there was no evidence of any lesson learnt within the service. All members of staff we spoke to consistently told us they received no feedback after reporting accidents/incidents. A member of staff told us, "I will speak to the managers about incidents, write them in the daily notes and report to the managers. But after that they do not communicate with us."

Using medicines safely

● We found gaps in medication administration records (MAR). Although stocks of medicines were correct, the stock record on the MAR did not tally with what people had been administered.

● One person's relative told us they were carrying out the person's MAR audits due to the number of discrepancies and gaps in the person's MARs. We saw those audits and noted they were able to identify gaps and discrepancies that the internal audits had not identified. This meant that the person was at risk of not receiving their medicines as prescribed.

● Medicines were stored securely.

The provider failed to ensure the proper and safe management of medicines. 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

● Some relatives of people using the service told us that changes were needed in the attitude and manners of some staff. One person's relative told us, "There was intimidation in administering medicines. Staff were approaching her not giving her personal space and speaking without respect, saying only 'Head back, open your mouth'. This was more than one occasion". The provider had taken appropriate action to deal with this, however, further improvement was required to improve the values, attitude and culture of staff within the service.

● Staff did understand how to report a concern but did not have a full understanding of where to report allegations of abuse if the management team does not act on it. This meant that local authorities, the Care Quality Commission (CQC) and the local safeguarding team would not be notified about incidents happening in the service and would not be able to act on them.

● One person living at Spode Close was known to make unconfirmed allegations of abuse against staff and family members. However, there was no robust plan on what to do with such allegations. They were recorded as incidents, but it was not clear if any action had been taken to address the allegations. This meant there was a risk that that potential abuse would not be investigated and the person harmed would not be protected against the potential abuser. We remained unnotified about the allegations made by this person.

The provider failed to establish systems and processes to investigate, immediately upon being aware of, any allegation or evidence of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection the provider reported retrospectively all allegations of abuse to the Care Quality Commission, local safeguarding team and the police.

● Following our inspection a support plan in relation to a person making safeguarding allegations had been completed. This included information how the person should be supported.

Staffing and recruitment.

● The management team carried out necessary checks to ensure that agency staff deployed had the necessary skills, experience and training to provide care and support to people. However, there was no evidence of agency staff being trained in this same intervention technique as regular members of staff. This means people living at Spode Close would not be provided with this same consistent support when experiencing behavioural crisis.

● Staff told us that care provision was hindered by the lack of overall management of the service. A member of staff told us, "Some days there is no cover, no senior member of staff, no manager and we have to run the service on our own. When we had the previous incident [the deputy manager] did night shift before the incident took place but she switched her mobile off then. The peripatetic manager was not here and there was no one from the management team to speak to the police. I do not feel safe as a member of staff and I do not feel we have right support." Another member of staff told us, "It happens quite a lot that we are left without the management."

● People's relatives told us they were concerned about deployment of staff. One person's relative told us, "I worry that the inconsistency of staff, and the set up at Spode Close in terms of individual units, places [person] in a vulnerable situation due to staff working in isolation, as does the inability to have a consistent and experienced manager in post." One person's relative told us that the deployment of staff affected the person's ability to be supported according to their wishes.

● Staff were recruited safely. Recruitment checks were in place to ensure staff employed were sufficiently skilled and experienced to work with people safely. Prior to staff starting work, a range of checks were completed. These checks included identity and right to work, criminal records checks, and references from previous employment

The provider failed to ensure that sufficient numbers of suitably qualified, skilled and experienced staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection the provider introduced holiday cover and on call arrangements to ensure there was management working at the service.

Preventing and controlling infection

● We saw the home was clean and tidy, and odour free. Staff supported people throughout the day to maintain a tidy environment.

● Staff had access to Personal Protective Equipment (PPE) to prevent the risk of infections spreading.

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

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.
● One person had specific conditions stipulated in their DoLS authorisation. We found that not all the conditions were met at the time of the inspection. For example, the person's condition was reviewing weekly support plans for all aspects of their care. However, the person's support plans were being reviewed monthly.
● Staff we spoke to had undergone training regarding the MCA and DoLS and were aware of how to apply this legislation. A member of staff told us, "We need to presume that people have capacity unless assessed otherwise".

The provider failed to ensure that people are not deprived of their liberty for the purpose of receiving care without lawful authority. 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.

Staff support: induction, training, skills and experience
● All staff we spoke to told us they did not feel supported by the provider. A member of staff told us, "There is no support in difficult situations." Another member of staff told us, "There is lack of communication, lack of support. They do listen but they ignore our feedback."
● We saw records that confirmed staff attended training in autism, basic life support, moving and handling and safeguarding. However, staff told us that some training did not provide them with knowledge on how to support effectively people, who had particular needs. A member of staff told us, "[Person] is at risk of suicide

but our training does not cover it. It is online training, not specific enough to work with someone with that type of needs." Another member of staff said, "The training in intervention technique is no use, you cannot move around [person] like they show you." We were given examples where staff and the people they supported were left in hazardous situations. This meant that staff were not receiving training tailored to people's needs and were unable to keep themselves and people safe.

We found no evidence that people had been harmed, however, staff were not receiving appropriate training and support. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff, including agency staff, received induction. However, agency staff were not trained in the same intervention technique as regular members of staff. New staff worked with experienced staff until they were competent and confident to support people independently.
● Following our inspection the provider organised a meeting with staff to discuss their concerns.
● The provider reviewed and booked further training for staff following our feedback.

Supporting people to eat and drink enough to maintain a balanced diet
● People's weight was regularly monitored, however, the information about people's weight was not analysed and there were no actions taken where needed. For example, one person was at risk of obesity and gained four kilograms in one month. There was no action recorded on how this had been investigated and management were not able to explain to us how they had dealt with this change in the person's weight.
● Staff supported people to prepare their food and make healthy choices where possible. However, people's relatives provided us with mixed feedback on the quality of food. One person's relative told us, "Meals are not exactly healthy."
● People were supported to eat and drink sufficient amounts to maintain good health.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to moving in to the service. The pre-assessment process ensured people's care plans detailed guidance for staff on how to meet people's needs. However, the pre-assessment did not consider the personalities and the combined needs of people supported, and their compatibility. A member of staff told us, "We have to make sure people are locked in their rooms if [person] is out. [Person] may easily go to [another person's whose behaviour may challenge] flat if they want and we would not be able to stop them." Another member of staff told us, "Something has to happen for them the provider to address it."
● The management team was aware of most best practice guidance but had not ensured this was translated into records and delivery of care in the service. For example, oral care guidance released by The National Institute for Health and Care Excellence (NICE) was not incorporated into care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to maintain good health and were not always referred to health professionals when needed. We saw no evidence for a person living at Spode Close to be referred to a dietitian or GP after they gained four kilograms in one month. This issue remained unidentified in their care plan. We asked a healthcare professional about their opinion regarding the services provided by Spode Close. The healthcare professional told us they had not been involved with the service for a long time therefore they did not feel this would be appropriate to provide us with any comment.
● Information provided by healthcare professionals was incorporated into people's care plans. Staff followed advice given by other healthcare professionals and sought further advice when needed.

● People had 'hospital passports', so key information was available if a hospital visit was needed. However, we saw the hospital passports did not always contain all relevant information on how to support people safely.

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

● People's rooms were personalised and decorated with personal effects, furnished and adapted to meet people's individual needs and preferences.

● We saw that communal areas were clean and nicely decorated.

● Some furniture used in the service had half-open design. This means that people who were unable to retain some information would be provided with opportunity to see and feel what was inside, which could often help to reduce anxiety and avoid confusion.

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 good. At this inspection this key question has now deteriorated to requires improvement. This means people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People told us they were supported by staff with dignity and respect. However, they also told us that some of the people living at Spode Close were affecting their care and well-being. One person told us, "I can feel wary of another person living here." This meant people could not always be supported as they wished and they did not always feel safe accessing the communal areas if the person was there.
- Relatives of people could visit the home at any time. This supported people to maintain contact with those who mattered to them.
- Staff demonstrated their awareness of people's likes and dislikes, for example, they knew how people liked to have their drinks served and what foods they enjoyed.

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

- People were supported to make day-to-day decisions for themselves and were provided with information in formats which best suited their preferred mode of communication.
- People's relatives told us they were involved in the care planning process where appropriate. However, they told us they were not always listened to and changes in care plans were not always introduced in a timely manner. One person's relative told us, "We told them how to do things but it takes them too long to act on our feedback." Another person's relative told us that despite raising this together with the person's social worker, the service repeatedly failed to apply for the person's bus pass.

Respecting and promoting people's privacy, dignity and independence

- People were supported to be independent, however, sometimes their independence was limited by the deployment of staff. We saw that one person who was not feeling well asked staff to go out with them to do some personal shopping. They were told that there were no drivers on shift so they would do the shopping later when they got better.
- Confidentiality was supported. Information was locked away as necessary in a secure cupboard or filing cabinets. Computers and electronic devices used by the provider and staff were password protected to keep information secure.
- Staff respected the privacy and dignity of each person and gave us examples of they how they did this. For example, by shutting people's doors when supporting them with personal care or by knocking before entering people's bedrooms.

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 requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

At the last inspection we noted that the provider failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. It meant improvements were not made to the quality and safety of service provision. This was a breach of regulation 16 (Receiving and acting on complaints) 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 16.

● The system for recording complaints and actions taken to improve the service as a result of the complaints was ineffective. We were told by the provider there were no complaints raised with the service within the last 12 months. However, people's relatives told us they had frequently raised their concerns and complaints with the service. One person's relative told us, "It was quite alarming to come here and to see my daughter's bed not made up or being dirty. We had to take photographs to show them how we expect laundry to be done. I have monthly meetings with them regarding changes and inaccuracies in [person's] care records." Another person's relative told us that the issue they raised with the person's social worker before our previous inspection in July 2019 still remained unresolved. This meant that the service failed to support the person to apply for their bus pass which had expired two years ago. Although the concerns had been raised verbally, they were not recorded which meant the service did not act in line with their own policy.
●People told us they knew how to complain. One person told us, "If I had a complaint, I would go to the deputy manager."

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

At our last inspection we found that the provider had failed to ensure people received care and supported that was personalised to their needs. This was a breach of regulation 9 (Person centred care) 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 9.

● People's needs to promote their independence and provide access to the local community were not always supported and so did not reflect elements of the principles and values of Registering the Right Support Guidance.
● One person's care file mentioned their favourite activities were singing and dancing. However, we saw no evidence of the person being supported to pursue their hobbies in the community. Another person's care file stated the person enjoyed swimming. However, there was no evidence of this person going to a swimming pool. When we asked staff, they told us that after an incident in the swimming pool they were afraid to support the person with swimming.
● We found evidence that care plans were not updated in response to certain incidents and occurrences. For example, one person's care plans were not updated in spite of two police incidents and an allegation of abuse. This meant staff were not consistently provided with most accurate guidance to meet people's needs effectively and safely.
● Some care plans contained information that was out of date. For example, one person's care file stated that they had not gone out for a long period of time. However, they started going out for a walk a few weeks before our inspection and went out for a walk on the day of the inspection.

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.
● Individual communication plans and guidelines were in place on how to communicate with people. Staff were aware of people's communication needs and knew how to communicate with them effectively.
● Not all care plans were created in an easy to read or accessible format. We saw that one person's care plan was just plain text. This means the person would not be able to read their care plan as they could not communicate using written language.

End of life care and support
● None of the people currently living at the home required support with end-of-life care at the time of the inspection.
● The management team told us they would respond to any wishes or advance wishes should they support anyone with end of life care. They also said as needed contact would be made with other appropriate services.

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 inadequate. At this inspection this key question has remained the same. 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

At our last inspection the provider did not have effective systems in place to monitor and improve the quality of the service. This was a breach of regulation 17 (Good governance) 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.

● People living at the home were not protected and supported to be safe as the provider did not have full oversight of the service. There was lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were inadequate auditing systems in place to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home.
● Quality audits had not been effective. Audits carried out by the provider had failed to identify issues revealed at our inspection such as no notifications about incidents/accidents sent or gaps in health and safety checks.
● The provider had not reported incidences of potential abuse to the local safeguarding authority so investigations could take place to ensure people's safety. Accidents and incidents were inconsistently recorded and there was no effective auditing of these records to ensure the appropriate actions were taken and lessons were learnt.
● Records were not always up-to-date, available or complete. The management on site had no access to all documents, therefore was unable to produce all the documentation requested at the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Was saw the results of a recent survey carried out among people's relatives. Some people's relatives raised issues regarding people not always making choices, lack of communication with the service, and lack of meaningful activities for people. We saw no evidence of a plan of action following the results of this survey.
● Staff did not feel listened to, respected or supported. They said they had told the management team about the issues relating to training, however, nothing had been done to address this issue. A member of staff told us, "I do not feel supported, if you go to them with a problem they do not do much." Another member of staff told us, "I said about this during my supervision that we are not safe."

● Despite some positive comments from one person's relative, we found that the culture within the service did not consistently promote providing people with safe, effective, person-centred care.

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 did not ensure the service adhered to the duty of candour. It resulted from the fact the complaints, concerns and incidents reported had been neither appropriately recorded, investigated nor were we notified effectively by them. People's relatives told us they were informed about an incident that had resulted in the evacuation of the service and the housing estate. However, they told us that no one officially apologised to them about the incident and the stress caused by it.

● Registered providers are legally obliged to send the CQC notifications of incidents, events or changes that happen within a required timescale. Statutory notifications ensure the CQC is aware of important events and play a key role in our ongoing monitoring of services. During our inspection, we discovered the provider had not made us aware of a safeguarding concern and police incident and had not submitted the relevant notifications to us.

The failure to ensure the Care Quality Commission had been notified without delay of significant incidents are a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We asked people, their relatives and staff about their opinion on the management of the service. While people living at Spode Close provided us with positive feedback about the deputy manager, feedback from people's relatives and staff was mostly negative. One person's relative told us, "Things are now improving." However, another person's relative told us, "I do not currently know who is the manager covering the service, they didn't contact us to introduce themselves. It feels like they don't support the needs of this service, that they are left to get on with it, and the corporate processes present barriers to anything getting done, e.g. replacement of the kitchen following a fire." A member of staff told us, "To be honest with you, the service has not improved at all. Sometimes at home I feel about to cry because I work here."

● The provider had not ensured the culture of the service fully supported the aims of national guidance for supporting people in care homes and with learning disabilities, such as Registering the Right Support.

● During our inspection we had lots of feedback from various sources about the staff and the deputy manager being overworked. At the time of our inspection the deputy manager was working a day shift as a member of permanent staff was unwell. However, staff told us, and records confirmed that the deputy manager often worked as a care staff member due to low staffing levels. Therefore, there were additional demands on the deputy manager to fill other roles and support people with daily care tasks. It was not evident how the deputy manager was receiving the right level of support to ensure that they could retain effective management and oversight of the service. The peripatetic manager responsible for the service was not there at the time of the inspection and it was not clear from the allocation sheets and rotas how much time they spent at Spode Close.

Continuous learning and improving care

● At our previous inspection we had identified four breaches of regulations. At this inspection we found that the provider had not only failed to address the breaches recorded at our previous inspection but was in breach of three further regulations.

● The provider had put in place an improvement plan for the service following our inspection. The operations director sent us further written arrangements for covering the period of time until the recruitment of a new manager to ensure the service was well managed.

Working in partnership with others

● The management team did liaise regularly with health and social care professionals regarding people's needs as they arose but did not clearly record the outcomes and actions of this.

● There was no evidence of involvement or partnership with any community groups or other providers for the purpose of sharing best practice ideas and improving the delivery of care.