Strode Park Foundation For People With Disabilities

Strode Park House

Inspection report

Lower Herne Road
Herne Bay
Kent
CT6 7NE

Tel: 01227373292
Website: www.strodepark.org.uk

Date of inspection visit:
17 April 2023
18 April 2023
19 April 2023

Date of publication:
29 June 2023

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Strode Park House is a residential care home providing personal and nursing care for up to 55 people. The service provides support to people with a physical disability. Many of these people also have other complex conditions including mental health, learning disability, autism, acquired brain injuries and sensory impairments. At the time of our inspection there were 43 people using the service including people staying for respite and rehabilitation.

Strode Park House is a large-listed building in extensive grounds. All people live on the ground floor across 4 wings. At the time of our inspection, 1 wing was closed for refurbishment. Each person had their own bedroom, and some had already been through a refurbishment. There were shared spaces such as dining rooms, bathrooms and lounges.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Medicines were still not being managed safely placing people at risk of potential harm. People were not being supported by enough staff to keep them safe and provide them with a quality of life. The registered manager were developing systems for learning lessons from accidents and incidents. Most risks to people had been assessed and ways to mitigate them found. However, the provider had not considered the risk of entrapment or falls from the bed rails in use.
Systems were not in place to ensure people received safe care and treatment that led to a good quality of life. Concerns found during this inspection had not been identified by the provider. Inconsistent management had not supported consistent implementation of new systems. Current best practice and guidance was not always being followed. Staff and management were not always following the provider's policies. The culture in the home was inconsistent from staff because there were inconsistent approaches and interaction with people.

The registered manager, who had been in post for three and a half weeks, had a clear vision of how they were going to improve the home. They had the support of the chief executive officer and board of trustees. Actions had already started to be taken in the short time the registered manager had been in post. The registered manager and chief executive were open and transparent during the inspection.

People were supported by some staff who were kind and caring. Other staff were task-based in their interactions with people. Mealtimes were a mixed experience for people, and we heard varied opinions about the food.

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.

Right Support:
People with learning disabilities and autistic people were not always encouraged towards independence. Their quality of life was limited by staffing levels impacted by national social care recruitment difficulties. Improvements were required to keep people safe.

People were unable to participate as part of the wider community as regularly as they would like. Support people received was mixed and agency staff lacked a thorough induction.

Right Care:
People with learning disabilities and autistic people were sometimes being supported by staff who knew them well. However, agency staff were less knowledgeable and systems to improve this were not always in place.

Staff support for people was mixed from some very kind and caring interactions to a lack of acknowledgement of people. Dignity was protected by staff knocking on doors. Systems were not always in place to encourage all people to communicate choices.

Right Culture:
Systems were not in place to ensure people with learning disabilities and autistic people received a high quality and safe level of care. Management had not always been stable to make sure a consistent approach was in place. Right support, right care, right culture guidance was not yet embedded into daily practice.

The registered manager had identified improvements were required around person-centred care. They had suitable plans in place which were being supported by the provider.

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 11 January 2023) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, some improvements had been identified. However, we found the provider remained in breach of regulations.

This service has been in Special Measures since 11 January 2023. During this inspection the provider demonstrated that some improvements have been made.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, safe care and treatment, staffing and governance at this inspection.

We served 2 warning notices about safe care and treatment and governance of the service that needed to improve. These have been upheld and we will follow up once the given time period has ended to check whether improvements have occurred.

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

The overall rating for this service is 'Requires improvement'. However, the service will remain in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 always well-led. Details are in our well-led findings below.	**Requires Improvement**

Strode Park House

Detailed findings

Background to this inspection

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

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

Inspection team
The onsite inspection was completed by 3 inspectors, 1 member of the medicine optimisation team, 1 Specialist Advisor pharmacist and 1 Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. A second ExE made telephone calls to relatives following the site visits.

Service and service type
Strode Park House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Strode Park House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post who had started 3 and a half weeks prior to this inspection.

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, fire service and professionals who work with the service. 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. We used all this information to plan our inspection.

During the inspection
We spoke with 26 people during the inspection and 1 relative. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 1 health professional and 35 staff including the registered manager, nurses, care staff, kitchen staff, activities coordinator and a range of other auxiliary staff. One trustee from the board spoke with us. We looked at a range of records including 34 care plans, recruitment records, medicine records, training records, health and safety records, incidents and accidents and policies.

During and following the site visits we liaised with the nominated individual who was the chief executive officer. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Following the inspection, 9 relatives were spoken with on the telephone and 2 relatives using a video call.

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.

Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure the safe management of medicines and to analyse and mitigate risks following incidents. 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 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were still not managed safely and placed people at risk of potential harm. People were not always receiving their medicines as prescribed. High-risk medicines such as blood-thinning tablets had run out of stock on occasions or refused and no action had been taken by staff. This placed people at risk of strokes and excessive bleeding.
● People being administered medicines that could be on a variable dose were placed at risk of harm because staff were administering incorrect doses. No checks had been made in line with blood tests to ensure doses were current. This placed people at risk of harm from medicines not being effective or being overdosed. We checked whether anyone had been admitted to hospital as a result of this. None was shared.
● Medicine records were not being updated or annotated in line with current best practice. This could lead to mistakes being made including underdosing or overdosing people. For example, staff administered insulin using doses that had used an abbreviated form which was identified as contributing to 'NHS Never Event' from January 2018 and therefore should not be used. An 'NHS Never Event' are serious incidents that are wholly preventable because guidance or safety recommendations are in place at a national level. No registered staff or management had identified this concern placing people at risk of the incorrect dose being administered.
● Unprescribed medicine that can be bought over the counter was found out of date in the home. This meant people may receive medicine that is not effective or spoiled. Additionally, some pain medicine was found to have been opened and had its prescribed label removed from it and moved to general use.
● Systems were only emerging to manage incidents since the new registered manager had started. Many incidents which had occurred since the last inspection lacked any form of action or learning from them to mitigate future risks. For example, an incident was found where staff levels at night dropped below safe levels had no action was recorded. Neither had it been alerted to external bodies in line with requirements.
● Some incidents and concerns identified during the inspection had not been recognised or recorded using existing systems. Many of the medicine concerns from the previous months medicine cycle had not been recognised or reported.

● Records had not been updated with actions that had sometimes been taken. For example, concerns about how a staff member inappropriately interacted in the home had been managed. Yet nothing was recorded on the incident forms about this.

Systems were not in place to manage medicines safely or to identify, analyse and mitigate risks following incidents or accidents. This is a continued breach in Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, we requested an action plan of how improvements would be made to keep people safe around medicines management. This was shared within the requested time frame and provided assurance the immediate risks would be reduced. The registered manager made safeguarding alerts to the local authority safeguarding team in response to people being placed at risk of harm.
● Systems were in place to store medicines safely including those requiring additional security. People's records had identified allergies, and this matched the medicine records. The management were ensuring that medicines were being managed safely for people who could become distressed or upset. The provider was making sure people were not overmedicated from medicines with a sedative effect.
● The registered manager had plans to improve the system for reporting and managing accidents and incidents occurring in the home.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to analyse and mitigate risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made, although not enough, so the provider was still in breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People with bed rails were placed at risk of becoming trapped or falling despite risk assessments now being in place. We found people with bed rails that were without covers, which could lead to limbs becoming trapped.
● The space between the top of the bed rail and the top of the mattress for 1 person was under the recommended level. By not having enough of a gap they were placed at increased risk of falling out of bed. We spoke to the registered manager who told us they would complete a full review of the use of bed rails around the home; this was shared following the inspection.

Systems were not in place to ensure all risks to people were identified and mitigated. This is a continued breach in regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements were found for people who were at risk of choking. Risk assessments were now in place and the kitchen had a good understanding of who required specialist diets. People requiring specialist diets and thickened drinks were offered them by staff in line with assessed needs.
● People at risk of pressure ulcers had equipment in place to reduce the risk of developing them. Staff were not always aware of how to check the correct settings of specialist mattresses were in place when supporting people.
● People who could become distressed or upset and express them in ways that could harm themselves or others had detailed care plans. Staff were aware of their preferences and needs so could reduce people's level of anxiety.
● Since the last inspection, the fire service identified people were not being kept safe in the event of a fire.

They had served enforcement to drive improvements. At this inspection, we found improvements were being made in line with the fire service requirements.

Staffing and recruitment

● People and their relatives had mixed views on whether there were enough staff to support them and keep them safe. One person explained regular staff were "very good" and continued, "Some unfamiliar staff should not be doing this work." Other comments included, "Staff always get me up late [in the morning]", "I think staffing has been problematic in the past, but it has improved dramatically" and, "[Person] is safe, but there is not enough staff."

● Staff felt there were not enough staff to provide people with a quality of life and at times keep them safe. Some concerns were found in records where staff numbers had dropped below the provider's safe levels. One person had not had basic clinical support resulting in them not attending a day centre. Another person had to wait a long time for assistance with intimate care.

● Rotas demonstrated that on multiple occasions staff levels dropped below the assessed safe staffing level shared with us following the inspection. This resulted in people only receiving basic care and treatment to keep them safe, though not providing them with a good quality of life. On many occasions people were witnessed in lounges and bedrooms with little or no social interaction for long periods of time.

● There were not enough staff to help people leave the home and spend time in the wider community such as going to the shops, visiting people or going to a local attraction. The service had relied on group activities in the home as care staff lacked the time to socially spend time with people.

People were not supported by enough qualified and competent staff to provide a good quality of life and always meet their needs. This is a breach in regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager had recruitment systems already in place although these were affected by the national shortage of care staff. They also had plans to introduce more volunteer roles to provide befrienders for people. The registered manager had reviewed current staffing levels to propose how to ensure people's quality of life would better be met.

● The provider recruited staff to the service safely. This included a range of checks including with previous employers. There were a team of staff who supported this process and easing the pressure for the management of the home.

Preventing and controlling infection

● Systems were not always in place to reduce the risk of infections spreading. A piece of health monitoring equipment was found to be dirty, and no staff or management had identified this issue. Areas of the home were found to be unclean. For example, the smoking area had large amounts of cigarette butts on the ground and a disintegrating box by it.

● Doors to sluice rooms had no locks around the home. Sluice rooms are areas where human waste can be safely disposed of to prevent harmful bacteria spreading. This meant people and visitors were able to access these areas at all times placing them at risk of spreading infections.

Systems were not in place to safely prevent the spread of infections. This is a breach in regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the registered manager arranged for areas to be cleaned up.
● 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 responding effectively to risks and signs of infection.
● 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.
● People were able to have visitors. Throughout the inspection we saw visitors spending time with people in areas of the home they chose to meet.

Systems and processes to safeguard people from the risk of abuse
● People were being kept safe from potential abuse. People told us they felt safe, and relatives agreed with this. Comments included, "I feel pretty safe", "[Person] is definitely safe", "[Person] is absolutely safe, yes" and, "I do feel [person] is safe there."
● Staff knew how to protect people from potential abuse. They recognised signs of abuse and knew who to report this to.
● The registered manager understood their responsibility around safeguarding. During and following the inspection they demonstrated the importance of informing other parties such as the local authority and CQC.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to ensure care was designed to meet people's needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made, although not enough, so the provider was still in breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had mixed views about the meals they had at the service. One person told us, "Kitchen staff are 'customer focussed' and you can ask for anything and they will try to meet these needs and are very accommodating." Whilst other people expressed they were not happy with the food. They gave reasons like, "There is limited choice", "The food is debatable…the taster session was lovely but in reality, it is not" and, "Not like it used to be."
- Relatives had mixed views of the food in the service as well. Comments included, "The roast dinners look nice", "[Person] is not happy with the food. It is not great", "The food is dreadful" and, "[Person] has a soft diet. He is not starved; I know they look after him."
- People did not receive consistent mealtime experiences including the level of social interaction. In one dining room people were supported by staff who interacted in a kind and joyful way with people. However, people supported in another dining room were not interacted with by staff and any communication was task focussed.
- People supported with meals in their bedrooms also had a varied experience. One staff member was seen supporting people with care and involved them in the meal. In contrast, another staff member was seen leaving meals sitting around whilst supporting other people. Little interaction occurred between the staff member and person they were assisting.
- People had little to no opportunities to develop skills around cooking and meals to improve their independence and quality of life. Mealtimes were set by the kitchen and most people ate at the same time.
- People who were able to verbally express their opinions were involved in their assessments being completed by a new member of staff appointed to update them all since the last inspection. However, there was little in place to support those who struggled with verbal communication to participate in their assessments. No alternative methods of communication had been explored such as easy read documents supported with symbols or pictures.

● Systems were not in place to ensure current standards, guidance and the law were embedded into practice. For example, guidance around use of bed rails and managing medicines. Nor had 'Right support, right care, right culture' always been reflected for people with a learning disability or autistic people.

This is a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had already started adding fresh vegetables back into the range of meals that were now being offered. The registered manager explained their plans for improving mealtime experience for all people. This included making it more person-centred and ensuring all people had social opportunities if they wanted it.
● The registered manager was aware of standards, guidance and law they should be promoting at the service. They had already worked with the chief executive officer to support them to improve in this area in the service. For example, they were ensuring quality of life guidance was going to be embedded into their future ways of working.

Staff support: induction, training, skills and experience
● People were supported by staff who had received a wide range of training and support. Comments included, "The staff appear to be well trained" and, "[Staff] are all well trained." This included specialist training to meet people's complex needs. However, competency checks had not always identified shortfalls in poor staff practices around medicines.
● Staff were positive about the level of training they received. Although, they sometimes struggled to find time to complete it due to current staffing levels. The provider recognised the value of face-to-face training and some was being delivered during the inspection. A member of staff was able to transfer onto it as they were unable to make the other available date.
● There was a 12- week induction that all new staff completed. This included a week of face-to-face information. However, improvements needed to be made about the induction new agency staff received. The registered manager had already identified this and had a plan of how to improve it.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to a range of health and social care professionals in line with their needs. A local GP completed regular visits to work with staff at the home and follow up on any concerns people or staff raised.
● The service had therapists employed to help with rehabilitation and supporting people have a better quality of life. This included physiotherapists and speech and language therapists. Staff had access to the therapists for advice and would continue the suggested programmes.
● Staff knew people well and were able to recognise when their health declined. They would contact the relevant health professional and seek advice.

Adapting service, design, decoration to meet people's needs
●Shared spaces such as lounges and dining rooms lacked personalisation. Sometimes they felt clinical rather than homely. The registered manager had recognised this and had plans to improve the shared spaces including involving people in the decisions.
● People could personalise their bedrooms in line with their needs and preferences. This included personal items, pictures and notices they had chosen to put up to inform staff about themselves.

● The provider had recently invested a large amount of money in ensuring all bedrooms had overhead hoists. This was to meet people's complex mobility needs and make sure they had suitable equipment in

place.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People who had capacity were asked for their consent before care was provided. Those who lacked capacity had decisions made in line with the principles of the MCA. This included involving others.
- The provider had ensured that people had an advocate they could speak with. The advocate attended board meetings to speak up for the people they represented.
- Systems were in place to monitor DoLS and ensure they were renewed in a timely manner. The registered manager was aware that any conditions needed to be met and followed.

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.

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

- People and relatives were positive about the staff who were permanent or regular in the home. Comments included, "I feel treated as an individual", "I like it here and the staff are really good", "The staff are wonderful, but you have to ask for help", "[Staff] are all very caring and attentive" and, "The staff I have seen are all kind and caring."
- However, people were not always receiving consistent care from staff. There was not consistent feedback about the approach from some staff. One person told us some agency staff are "disconnected" and continued, "Some are more willing and able than others." Observations by the inspection team reflected this. For example, the different experiences people had at mealtimes and how some staff used shared spaces as corridors.
- Staff did not provide consistent care and support for people. Some staff spoke fondly about people with care and compassion. They knew people well and spent time with them when they could. Some interactions seen reflected this approach staff had. Although, there was more of an emphasis on caring for rather than supporting people at times. For example, making a drink for someone rather than helping them to make their own drink. We witnessed derogatory language being used by some staff. For example, a member of staff asking another member of staff "Are you doing anyone?" whilst referring to supporting people with their meals.
- The registered manager led by example. Relatives commented that it was good to see the new manager around the home which was a positive change. The registered manager already had plans to improve the culture to make it more consistent and person-centred. This included increasing staff levels so staff could spend more time with people and ensuring consistency in approaches.

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

- People with limited verbal communication received less options to choose from. Or staff who knew them well made decisions for them. No alternative forms of communication were used around the service. Some people spent long periods of time alone in their bedrooms with no way to communicate if this was their choice. Others spent most of their time in their bed with limited options to get out.
- People who could verbally or physically express their views were able to make choices throughout the day. For example, some people able to propel themselves around the home spent time in different areas of the home. They were asked by staff whether they would like to join in organised group activities or what else they would like to do.

Respecting and promoting people's privacy, dignity and independence

● Some of the approaches in the service were not promoting independence for people with a learning disability and/or autism. For example, there were set times for meals and few places people could prepare their own drinks and meals at chosen times. The registered manager had recognised more opportunities for independence needed to be created throughout people's days.

● People who were more able were encouraged to remain as independent as possible. They were seen travelling around the home and choosing to have their own food outside of the prepared mealtimes.

● People's privacy was respected by staff. Staff were witnessed knocking on people's bedroom doors. When staff supported people with intimate care, they closed doors and demonstrated respect for people.

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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs; 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 the provider failed to ensure care was designed to meet people's needs and preferences including their social needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made, although not enough, so the provider was still in breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection the provider had recruited a member of senior staff to review all people's care plans. Improvements were found in care plans reviewed at this inspection. People who could be involved had been involved. However, no consideration had been made on how to involve those less able to verbally communicate.
● People were still not receiving the best quality of life because of the limitations around activities in the home. Many raised concerns about not leaving the home much and others were limited to spending most of their day in their bedroom. One relative said, "[Person] sits in her room all day. She is not encouraged. She watches television all day and she has become institutionalised." Other comments included, "Community access is not as much as I would like it to be. People should be going out more", "I would like to go out. I would like it to be better" and, "I would like to come out of my room more. I like to see other people."
● Activities in the home were limited to those run by the activity coordinator. Care staff were predominantly task-based due to the staffing issues and culture at the home. When care staff updated daily notes they often did not involve people. For example, on the first day of inspection, 5 staff were seen talking to each other in a dining room whilst completing people's electronic daily records. On another occasion, staff were seen not supporting people during an activity run by the activity coordinator.

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 not in place to ensure information was shared with people in relation to their individual needs. This was despite having communication records in their care plans. Reliance was placed on staff

knowing people well.
● The provider had not ensured that information was accessible to all people. For example, people where English was a second language had no records in their primary language. Information was not produced in a variety of methods such as pictorial, signing to support speech or objects of reference. There was a reliance on written verbal information sharing which was not respecting each person's needs.
● People who had limited verbal communication had not been provided with alternative methods of communication. Reliance was placed on them nodding their head, blinking eyes or putting thumbs up. This meant it was hard for those people to share their views and make choices.

Systems were not in place to ensure care and support was delivered in a person-centred way. This is a continued breach in regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager was already in the process of increasing the staff and volunteer levels. This would improve people's personalised care and quality of life. They recognised improvements needed to be made about how information was made accessible.
● People and relatives spoke highly of the activity coordinator. This included how they interacted and respected their wishes and interests. The activity coordinator tried to involve people as much as possible. Comments included, "[Activity coordinator] is a dynamite" and, "[Activity coordinator] gets the heads up; she has a lot more energy about her."
● People were supported to remain in touch with those who were important to them. Visitors were made welcome at the service and could meet were the person chose. When family were unable to visit the activity coordinator encouraged people to use technology to speak with them.

Improving care quality in response to complaints or concerns
● People able to communicate verbally were confident they could raise concerns and action would be taken. Comments included, "The manager's door is always open" and, "[Management] are all responsive and proactive generally." However, there were a lack of systems in place for people who had verbal difficulties.
● Relatives had more mixed views about whether concerns were acted upon. Some felt their concerns were listened to and acted upon. One relative said, "If I felt I should complain then yes. A 100 per cent I would tell them. I would not hold back. I do not have the need to complain." However, in the past some relatives recalled situations where they did not feel their concerns were listened to or acted on in a timely way. The registered manager was acting upon them retrospectively since their arrival.
● Systems were in place to manage complaints and concerns. However, action taken had not always been recorded in response to the written record. The registered manager had plans to separate the concerns and complaints into a separate system.

End of life care and support
● People had their end of life wishes and needs considered. Where they wanted specific things then it was recorded in their care plan.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider failed to have robust oversight of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made, although not enough, so the provider was still in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were still not established or effective for overseeing the safe care and treatment people received. Nor were they allowing people to live a good quality of life. No oversight was in place for medicine management. Infection control did not have adequate management oversight because areas and equipment were found dirty during the inspection.
● The provider failed to put a consistent and effective management plan in place between January 2023 and March 2023. A management transition team had been established consisting of representatives of the provider and senior staff. However, they had not recognised many of the concerns identified during the inspection such as medicine administration and learning lessons from incidents. This meant people were being placed at significant risk of harm. Nor had they identified policies for practices such as wound care and pressure care were not in place. The provider created these policies and procedures during the inspection. This meant staff would not be able to hold to account if things went wrong for people.
● The management systems put in place had failed to drive enough improvement since September 2022. For example, breaches in multiple regulations were still identified at this inspection. People's quality of life had not improved enough. On multiple occasions people were witnessed with little or no interaction for long periods of time. Lessons were not being learnt from accidents, incidents and near misses. Complaints and concerns were not consistently managed until the new registered manager started.
● The provider failed to ensure adequate systems were in place to send statutory notifications in line with legislation. Statutory notifications are significant events that affect the service, the provider should inform the CQC to allow them to externally monitor people's safety and care. For example, 1 person fractured their ankle whilst on a trip to the local hospital and was admitted to hospital. CQC also had not been informed when staffing had dropped below the provider's safe assessed levels. This meant CQC would not be able to effectively monitor people's safety and quality of care.
● The provider's policies and procedures were not always being followed by staff or management. For

example, medicines were not being managed in line with the medicines policy. Nor were quality assurance systems and infection prevention and control in place in line with the home's policies. This meant there was a risk people would receive unsafe and poor-quality care.
● The provider failed to ensure people were kept safe in the event of a fire. Between the September 2022 inspection and this inspection, the fire service completed an inspection. This identified concerns which the provider had not, resulting in the fire service taking its own enforcement action. This meant people had been placed at risk of harm in the event of a fire.
● The provider failed to make sure current best practice and guidance was embedded into practice. People were found not to always have their quality of life met. Guidance such as 'Right support, right care, right culture' was not in place for people with learning disabilities and/or autistic people. Bed rails were not being used in line with current best practice. This meant people were at risk of unsafe or poor quality of care.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This is a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was open and transparent with the CQC throughout the inspection. They explained they had only had three and a half weeks to drive the improvements they had planned. Reassurance was demonstrated when many of the concerns found had already started to be identified by them. The registered manager also had a history of delivering high-quality and safe care in previous locations.
● The provider supported the registered manager during the inspection including providing assurance they listened and wanted to improve the service. Action plans shared were comprehensive about how they were going to resolve the highest risks to people in a timely way.
● Improvements were already found around fire safety as examples of how the provider and registered manager were demonstrating a positive culture of learning and improvement. For example, regular fire drills were being carried out to ensure all staff had practiced them. A bedroom in a wing that was being refurbished was set up so staff could simulate how to support less mobile people in the event of a fire.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Systems had not been put in place to manage inconsistencies around culture, inclusivity and person-centred care. Some staff referred to the home being an extended family. Observations throughout the inspection demonstrated there were some kind and caring staff.
● However, other staff were seen limited to task-based interactions and treated shared spaces as corridors. There were occasions we witnessed when staff chose to speak with each other rather than people. Systems had not been put in place to manage these inconsistencies.
● The registered manager had identified this issue including around suitability of language used by staff. They had plans to ensure there was a positive culture that was person-centred, open, inclusive and empowering for people. One person said, "There has been some peaks and troughs, but it is definitely on the up. The manager is going to be very good when she gets into her role. [Registered manager's] heart is in the right place."
● Other comments included, "The new manager is doing very well…there has been a boost in morale", "I like the new manager, she is caring" and, "I have just had an email introducing herself as the new manager. It was very warm. I am hoping for some positive changes."

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 registered manager and provider were clear about their role and responsibilities around the duty of candour. The registered manager had already acted upon concerns they had learnt about by being open and transparent with people and where necessary those important to them. This included reviewing historic concerns where they were rectifying them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems had not been in place to formally request feedback from people, the public and staff. One person was chair of the 'residents' group' and advocated for other people. They met regularly with the board of trustees to ensure the people were listened to. However, improvements could be made for those to speak up with little or no verbal communication.

● Relatives confirmed they had not received any formal methods of being able to provide feedback such as questionnaires. However, many felt the registered manager, who was new in post, was beginning to change this. Comments included, "There has been no questionnaires, but things might change now", "Our [relative] said you never used to see the other [manager] but this one goes round out and about" and, "The new manager has only been there about a month. We had a meeting this morning actually."

● The registered manager had an open-door policy. We regularly saw them around the home and greeting people, relatives and staff. One staff member took advantage of the open-door policy by feeling confident to come in whilst the inspection team was speaking with the registered manager.

Working in partnership with others

● Staff worked well with other health and social care professionals. One health professional told us, "The new manager is more proactive." They explained systems had been set up so staff could regularly make contact for any information and advice.

● People were able to access therapy within the home and more specialist services externally. However, there had been 1 occasion when a person was unable to attend an appointment due to a non-wheelchair accessible vehicle being provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems were not in place to ensure care was always personalised to people's needs and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by enough competent staff to meet their needs and provide a high quality of care.

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
Treatment of disease, disorder or injury	The provider was not ensuring people received safe care and treatment including around medicine management.

The enforcement action we took:

We warned the provider they needed to make improvements by a set date which we would go back and check.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems were not in place or effective to ensure people received safe and high quality care.

The enforcement action we took:

We warned the provider they needed to make improvements by a set date which we would go back and check.