Parkhill Support Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

About the service
Parkhill Support Services Ltd is a supported living service providing personal care for up to five people living with learning disabilities, autistic spectrum disorder and complex health needs. At the time of our inspection there were four people using the service.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting some of underpinning principles of "Right Support, Right Care, Right Culture.

Right support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Care and support was not planned to meet individual needs and ensured that people were consistently supported to have a fulfilling and meaningful everyday life that included achieving aspirations and goals. People and their relatives were not always informed and encouraged to make decisions about the care and support in place.

Right care:
Medicines were not safely managed in a way that ensured it was effective and achieved best possible health outcomes. The service had not fully explored how to present information in accessible ways to meet individual needs. Assessments of people's needs had been completed but did not consider best outcomes for people as individuals or as a group. The service did not always ensure that risks faced by people had been assessed and planned for. Not all staff were committed to providing an individualised care and support, and there was not enough staff to ensure assessed needs were met. .

Right culture:
The provider did not have effective oversight of the service. An effective quality assurance system was not in place. Staff did not receive support through training, supervision and meetings to ensure they had the knowledge and skills to meet people's needs. The service did not work effectively with other agencies to drive improvement. Lessons were not learnt from accident and incidents, safeguarding and complaints to drive improvement. There was an organisational structure in place, but staff did not always know of their individual roles and responsibilities.

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

Rating at last inspection:
This service was registered with us on 20/03/20 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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

We have found breaches in relation to regulation 9 (Person centred care), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment), Regulation 16 (Receiving and acting on complaints), Regulation 17 (Good governance) Regulation 18 (Staffing) and Registration Regulation 18 (Notification of other incidents) at this inspection.

We have made recommendations about staff recruitment records, access to healthcare services, respecting and promoting privacy, dignity and independence and meeting people's communication needs.

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

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 will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means we will start processes that will prevent the provider from continuing to operate the service.

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

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 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**

Parkhill Support Services Ltd

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of this inspection, there was no registered manager in post since July 2021.

Notice of inspection
We contacted the service on the day of the inspection to inform them of our visit. This was because the service is small, and the manager is mostly located at another service. We wanted to be sure they would be

available to speak with us. The inspection activity started and 17 March 2022 and ended on 26 April 2022. We visited the office location which was on the same premises as the supported living scheme on 17 March 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we held about the service since they registered with us. We sought feedback from health and social care professionals and the local authority that commissioned the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two relatives on the telephone to gather their views about the service. We were not able to gather people's own experience or views on the day of the inspection because they were either out in the community or did not wish to speak with us. We also spoke with four staff including the manager, a quality manager and two support workers.

We reviewed a range of records. This included four people's care records and two medication records. We looked at three staff records in relation to recruitment and supervision. We also looked at a variety of records used in managing the service, including policies and procedures.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed and stored safely. One person's medicines stock was kept in a plastic storage container and stored under a bed in the staff room. The manager moved the medicines later into a locked cupboard used to store other items including documents. This showed an appropriate storage facility was not available for all medicines.
- Fridge and room temperature checks were not consistently taken to ensure medicines were stored within the manufacture's requirements. This posed a risk of the medicine not working as it was intended to.
- People were not supported to take their medicines as prescribed by healthcare professionals. Staff completed medicines administration record (MAR); however, there were several gaps in the MARs and staff could not explain why the medicines were not given. The system in place for when people took medicines with them whilst visiting relatives was inadequate because staff did not always record the number of medicines checked out or returned. Where people were prescribed topical creams, no MARs or body maps were maintained.
- A PRN protocol was not in place for 'as required' medicines to provide staff guidance on when and how they could administer this medicine. This placed people at risk of taking medicines unsafely.
- Medicines training was not up to date for all staff and medicine competencies had not been carried out. Appropriate systems were not in place to monitor and audit people's medicines.

A failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk to people were not always identified, assessed and with appropriate risk management plans. For example, we found that one person regularly refused their food despite living with diabetes. The service did not have an appropriate nutritional risk assessment and management plan in place.
- Staff were scheduled to lone work and were required to provide personal care to people. One person's risk assessment stated they had a history of making false allegations against other people and staff; including allegations of being touched inappropriately. However, there was no risk assessment in place to demonstrate this was a safe arrangement or practice. This placed both people and staff at risk of unfair treatment in the event of an allegation of abuse being made.
- Risk management plans were not updated to reflect people's current risks. One person was recently lost in the community. Their lone travelling risk assessment was not updated to include and mitigate their risk of being lost in the community again.
- Staff told us they followed the provider's process to record accidents and incidents. However, there was no process in place to analyse, identify trends or learn lessons to improve on the service provided.

A failure to ensure risks associated with people's care was assessed and plans implemented and delivered to mitigate such risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk from abuse
● People were not always protected from the risk of abuse. Staff had completed safeguarding training; however, a member of staff could not explain their understanding of safeguarding or the types of abuse that should be reported. They also did not know how to escalate concerns of abuse to external authorities including the local safeguarding team and CQC.
●Where an allegation of abuse was made, the manager did not report this to the relevant authorities.
● During our inspection, we noticed one person was under constant monitoring and supervision. The manager informed us no one was under restrictive practices. However, social care professionals confirmed one person had authorisation for their liberty to be deprived. The service was not aware an authorisation was in place and the conditions they had to comply with. The lack of adequate information placed people at risk of unsafe levels of restrictions and support.

A failure to protect people from the risk of abuse 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.

The provider had safeguarding and whistleblowing policies and procedures in place. Staff told us they would report any concern they have to their manager to provide staff guidance.

Staffing and recruitment
● The service did not always have enough staff available to safely support people's needs. Relatives said the lack of appropriate staffing levels was having a negative impact on the care and support delivered.
● The manager told us staffing levels were planned based on assessed individual needs. A staffing rota we reviewed showed the number of staff on shift matched the numbers planned for. However, we found that the staffing level had been reduced from two to one due to lack of enough staff and did not meet people's assessed needs.
● Where one member of staff was on shift, they were responsible for supporting four people for example, to prepare their meals, attend to their personal care, administer medicines and engage in activities of choice. People were meant to have one-to-one staff support. However, this was not being carried out due to lack of staff.
● Staff told us the staffing level in place was not suitable and more needed to be done as this was having an impact on staff wellbeing.
● The service had low permanent workforce, therefore bank staff covered several vacant shifts where possible. It was the provider's policy not to use agency staff. Therefore, staff sometimes worked 24hour shifts without the appropriate breaks which put them and people at risk.

A failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were not assured appropriate recruitment checks were followed before staff began working at the service. The provider had a recruitment checklist where they recorded various checks they had carried out for new staff. The checklist was a tick box and did not reference the application form, any gaps in employment, any risk assessment carried out or the references acquired.

We recommend the provider to consider current guidance on maintaining staff recruitment records and take action to update their practice accordingly.

Preventing and controlling infection

● People were protected from the risk of infection. The provider had policies and procedures on infection control and prevention which provided staff guidance on how to minimise or prevent the spread of diseases.

● Staff had completed infection control and food hygiene training. Staff wore personal protective equipment (PPE) including gloves and masks when supporting people.

● Checks were in place to prevent visitors from catching and spreading infections.

● People using the service and staff were undertaking regular tests to identify and minimise the spread of infections. The provider encouraged the uptake of vaccination for people and staff supporting them.

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.

This is the first inspection of this newly registered service. We have rated this key question requires improvement. 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 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

- People's right were not always protected because the service was not always working within the principles of MCA. The service did not have a consent to care and support system in place.
- Both managers and staff told us people had capacity to make day to day decisions for themselves. Where people could not make specific decisions for themselves, a mental capacity assessment was carried out in areas including medicines, coronavirus injection and personal care.
- However, information on the capacity forms were contradictory as to whether people could make these decisions or not. For example, information in one person's record, stated they could not make a specific decision, however, they had signed the document to demonstrate they had made the decisions.
- Where people could not make specific decisions for themselves, a best interest decision was in place. However, this decision was made by a member of staff without any consultation with people, their relatives or healthcare professionals as required under the principles of MCA.
- Some people's care records including tenancy agreements were signed by their relatives, despite relatives not having the appropriate authorisation to make formal decisions on their behalf.

The failure to obtain consent to care and support was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff support, training, skills and experience

● Staff were not always supported or trained to perform their roles. The manager and staff confirmed new staff completed an induction when they began working at the service. However, we were not assured new staff were monitored and supervised during probationary periods to ensure they had the knowledge and skills to complete their duties. We were also not provided with staff induction records even though we requested for them.

● Staff supervisions were not carried out in line with the provider's policy. The manager informed us each staff member should have six supervision sessions a year. However, they had carried out one supervision each for three members of staff. We were not provided any further record of when supervision was last carried out. A member of staff told us, "I have not had regular supervision due to the waves of changes of management."

● Annual appraisals were not completed to support staff professional development. Both managers and care staff could not tell us if an annual appraisal had been carried out in the year 2021 and 2022.

● The provider had systems in place to monitor staff training, but staff had not completed refresher training in areas including medicines administration, fire safety, first aid and autism awareness. The lack of staff support, and training placed people at risk of receiving unsafe care and support.

A failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were available to support people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Appropriate needs assessment was not always in place to ensure the service was suitable and could meet individual needs. A relative informed us, due to their loved one being more independent, their needs were not attended to.

● The manager informed us people's needs were assessed before they began using the service. Despite this, the assessment process did not consider the dynamics of the different levels of the support needs of each person and how this may impact the overall level of support delivered. The service also did not consider the knowledge, skills and ability of staff to manage the differing needs of people.

● People using the service used to live at another accommodation owned by the provider. We could not find any initial assessment or consultation of when, how and why they were moved to this service.

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat and drink; however, the food choices were not always healthy for their wellbeing. A relative said, "Their diet is absolutely disgusting, everything is freezer or buttered and [my loved one] has gained a lot of weight."

● Care plans did not always contain information about people's dietary needs; including their likes, dislikes, preferred meal choices and the level of support staff should provide. For example, a care plan stated, 'Staff will support [person's name] to manage their nutritional needs around their diabetes themselves'. There was no further information about what support staff should provide as the person was fully dependant on staff to prepare all their meals. .

● We brought this issue to the provider's attention and they told us they would be reviewing each person's care and support plan to ensure their needs were met. We will follow-up on this at our next inspection.

● Staff told us they planned weekly shopping list and menus, and they involved people to purchase their grocery and prepare their meals. Some people were independent and made their own breakfast and packed

lunches.

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

- Each person had a hospital passport; however, information in the hospital passports were not always complete and up to date. This placed people at risk of receiving unsafe care and treatment from emergency and hospital teams.
- People did not always have a health action plan to attend regular health checks. Appropriate systems were not in place to record and act on recommendations from healthcare professionals.
- People were supported to access healthcare services; each person was registered with a GP. Some People could attend health appointments independently; where required, relatives or staff supported them. However, relatives told us they had taken-on the responsibility to attend health appointments to prevent people missing them.

We recommend the provider consider current guidance on supporting people to access healthcare service, maintain accurate records and take action to update their practice accordingly.

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.

This is the first inspection of this newly registered service. We have rated this key question 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

- Not all staff were kind and caring. A relative said, "The long-standing staff are caring, but the others are not there for the right reasons." Another relative said, "There are two caring and responsible staff in there [names mentioned], the rest of them are mostly on social media with earpieces on."
- People's life histories, preferences, likes and dislikes were not included in their care plans to help staff develop a relationship with them and to provide care and support that met their needs.
- Not all staff knew people well and the level of support they required. Relatives said, staff had to be prompted to support their loved ones because they were either too busy or did not care. One relative informed us, "The staff just do not understand my [loved one's] medical conditions."
- Staff did not always understand the importance of working within the principles of the Equality Act and to support people's diversities in relation to their protected characteristics including race, disability, sexuality, sexual orientation and religion. For example, staff did not provide the appropriate level of support people required with their sexuality and relationships.

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

- People and their relatives were not actively encouraged to be involved in their care and support. A relative informed us, "[Manager's name] was meant to speak with me and [my loved one] to develop a new support plan, risk assessment and the care and support in place; we are still waiting for their call."
- Relatives said communication from the service was poor and they did not receive important information to provide the appropriate level of support their loved ones required. Where relatives shared information with staff, this was not always cascaded to relevant staff members to be actioned.
- Regular meetings were not held with people to discuss important things that mattered to them; such as their meals, activities, environment or how they would like to live together.
- A key worker system was in place; however, regular meetings were not being held to ensure appropriate support was in place and individual needs met. A key worker is a named member of staff responsible for coordinating a person's care and providing regular reports on their needs or progress.

The issues above were breaches of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- We received mixed views about how people's privacy and dignity was respected. We saw, and relatives confirmed facilities in the home such as the living room was not suitable for the number of people living at

the service and the bathrooms and toilets were not safely maintained. They said people were not always supported to maintain their personal hygiene and grooming or the cleanliness of their home.

● We received mixed views about maintaining confidentiality. Staff told us information about people was kept confidential and shared on a need to know basis only. However, relatives said staff were sometimes overheard discussing people and their relatives in unkind ways.

● We received mixed views about how people's independence was promoted. Staff informed us people were encouraged to perform tasks they were capable of doing. This included making their own breakfast, tidying their room, washing dishes and supporting staff to prepare meals. We found and relatives confirmed more could be done to improve and promote people's independence.

We recommend the provider to consider current guidance on respecting and promoting privacy, dignity and independence and take action to update their practice accordingly.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question requires improvement. This meant people's needs were not always met.

Planning personalised care

- Each person had a care and support plan in place; however people's needs were not always met in areas including medicines, nutrition and personal care.
- Care records were not complete, consistent and reflective of people's current needs. For example, staff told us, no one self-medicate. Yet a person's care plan stated, "Staff to support [person's name] to self-medicate. This puts people at risk of receiving unsafe care and support.
- There were no system in place to support people to work towards positive outcomes based on their strengths and abilities. Goals were not identified, set and monitored to improve people's independence.
- Commissioners informed us each person had been assessed and funded a minimum of 30 hours a week to have a one to one session with staff. However, this arrangement was not in place to ensure the care and support planned for people was delivered.

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

- People were not always supported to participate in social activities of their choice. On the day of our inspection, three people were out independently to a day centre or college to participate in various activities. One person who could not safely access the local community independently was not engaged in or stimulated with any activities of choice. We found the person would like to participate in various social and leisure activities. However, due to the poor staffing levels, staff had not been able to take them out for such activities.
- There was total lack of stimulating activities at the service. A relative told us it was sometimes worrying when their loved one was not at the day centre because colouring for an adult was not an activity. Another relative said, "My loved one stays in their room a lot of the time sleeping or otherwise hanging out in the lounge because there is no activities."
- People were supported to build relationship with those important to them. People visited their relatives or met up with them for appointment or leisure activities. However, relatives informed us, they did not have a choice but had to 'step up' to support their loved ones because the service lacked appropriate and adequate staff.

The issues above were breaches of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Complaints were not always handled satisfactorily. The provider had policies and procedures on how to make a complaint and what people and their relatives should expect in response to complaints. However,

the provider's policies were not always followed. A relative mentioned, "I have a lot of messages from [manager's name] but does not address any issues raised."

● A complaint log we reviewed showed where people or their relatives had made a complaint. The service did not always act to investigate and resolve their complaints. For example, where a relative made a complaint about a member of staff, there was no information on how this was investigated, any actions taken with the member of staff, any management plans put in place and how lessons learnt were shared with staff. The complainant also redrew their loved one from using the service because they were dissatisfied.

● The provider was not keeping within their set time frame to resolve complaints promptly. For example, a complaint made on 5 October 2021, showed 5 November 2021 set as the time limit to close the complaint. However, on the day of our inspection on 17 March 2022, this complaint has not yet been closed.

A failure to manage complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff told us they understood people's communication needs. A staff member told us, "I used short, short sentences to support [person's name] and where required we give them two options." They said this enabled the person to understand information and make informed choices where required.

● However, people's communication needs were not consistently met. Information was available to people in easy read and pictorial formats including hospital passports, surveys and tenancy agreements. People had varied communication needs but information was not always tailored to meet their individual needs. For example, one person used Makaton as their alternate means of communication. However, there was no information in their care files about some common Makaton signs they used so staff could understand them. Makaton is a language programme that uses signs, symbols and speech; giving a person different options when communicating.

We recommend the provider consider current guidance on meeting people's communication needs and take action to update their practice accordingly.

End of life care

● At the time of this inspection, no one using the service required end of life care or support. There was no advance care plan in place to ensure people's last wishes were respected.

●We raised this with the manager. They told us they would develop an advanced care plan and would consult with people, their relatives and health and social care professionals to ensure people have an advance care plan in place and to ensure person's end of life care needs and wishes would be met. We will follow-up on this at our next inspection.

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.

This is the first inspection of this newly registered service. We have rated this key question inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The service was not well-led and there was a lack of management oversight. There was no registered manager in post since July 2021. The current manager started working at the service in December 2021 and had applied to CQC to become the registered manager.
- There was an organisational structure in place. However, staff roles, responsibilities and accountability was unclear in areas including audits and staff supervision.
- A regular auditing system was not in place. An audit completed in October 2021 by the provider's quality team identified several areas of concern including medicines management. At the time of this inspection action had not been taken to address the issues identified.
- Records including medicines records, care record, mental capacity assessments, hospital passports and staff records were not always accurate, complete and up to date. People's records did not always contain important information such as their health conditions, list of medicines, next of kin, GP and any known allergies. The lack of adequate information placed people at risk of receiving unsafe care and treatment.
- Staff training records, supervision and appraisals were not kept up to date. Staff recruitment records did not include detailed information of checks completed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- People and their relatives' views were sought through quarterly feedback questionnaires. The results from the questionnaires were not analysed with action plans to drive improvements.
- In March 2022, a relative, provided negative feedback throughout the questionnaire and said their complaints had also not been addressed. These issues had not been resolved to improve the standard of the service provided.
- Staff meetings were not regularly held and recorded. Staff told us they did not feel supported and listened to and found it difficult to raise concerns because their views were not taken into consideration and acted on.
- The service did not have an effective system in place to learn lessons from accident and incidents, safeguarding adults, complaints or audits.

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

● Managers were not always proactive to provide a meaningful, high-level, person-centred care. The culture at the service was not always positive and managers and staff did not always work together to improve on the service.
● People and their relatives were not always happy with the standard of care and support provided. A relative told us, "[Parkhill support] is absolutely totally awful." They said there had been long-standing lack of leadership.
● Managers were not always proactive in empowering people to be involved and to make decisions about their care and support needs. They had not always liaised effectively with those important to them to ensure that the care and support provided was meeting their needs.
● Managers knew of their responsibility under the duty of candour that they had to be open, honest and take responsibility when things went wrong. However, information was not always reported and recorded when things went wrong. For example about an allegation of abuse and neglect.

The issues above were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Working in partnership with others
● The service was not working effectively with health and social care professionals to drive improvement.
● People were not being reviewed by health and social care professionals to ensure the care and support in place was meeting their needs. One person had a review with healthcare professionals. However, there were no records to demonstrate other people had received a recent review from health and social care professionals. Staff could not remember when last people had received a review.
● Social care professionals from a local authority informed us they had concerns about this service and the care and support 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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were put at risk of receiving unsafe care and support because the provider had failed to plan care and support that met their individual care needs. Regulation 9(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act by seeking consent from people in line with the requirements of the Mental Capacity Act 2005 (MCA). Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from the risk of abuse, neglect and improper treatment. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not investigate and act on complaints to ensure people and their relatives

were satisfied with the way their complaints were handled.
Regulation 16(1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure sufficient numbers of staff were deployed to meet people's needs. Staff did not receive the appropriate training and support to carry out the duties they were employed to undertake. Regulation 18 (1)(2)

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure risks relating to the safety and welfare of people was identified, assessed and managed effectively. Medicines were also not managed safely.

The enforcement action we took:

The provider did not ensure risks relating to the safety and welfare of people was identified, assessed and managed effectively. The provider did not ensure the safe manage medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure appropriate systems were in place to assess, monitor and improve on the quality and safety of the service. Records were not accurate, complete and up to date.

The enforcement action we took:

The provider did not ensure appropriate systems were in place to assess, monitor and improve on the quality and safety of the service. Records were not accurate, complete and up to date.