Autism Hampshire

Autism Hampshire - 102b Brockhurst Road

Inspection report

102B Brockhurst Road
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Autism Hampshire - 102b Brockhurst Road is a residential care home providing accommodation and personal care to people with a learning disability and autism. The service can support four people and at the time of the inspection three people were being supported.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability with the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

Based on our review of key questions safe and well-led, the provider was not able to demonstrate how they were meeting the underpinning principles of Right support, right care right culture. The service was not maximising people's choices, control or independence. There was a lack of person-centred care and people's human rights were not always upheld. A lack of timely action by leaders to ensure the service was well staffed and safeguarding incidents were responded to meant people did not lead inclusive or empowered lives.

People did not receive a service that always ensured their safety.

The provider had not established an effective system to ensure people were protected from the risk of abuse. Risks to people's health and wellbeing had not been monitored or mitigated effectively. People were at risk of harm because staff did not always have the information they needed to support people safely. A number of safety concerns in relation to the environment were identified. The service was not always clean or secure. Medicines were not managed safely, and medicine administration records were not always complete. The provider had not ensured there were sufficient numbers of competent and skilled staff to support people safely.

The service was not well led.

The provider did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified all of the concerns in the service and where they had, sufficient improvement had not taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. Indicators of a closed culture were identified, and staff morale was low. This meant people did not always receive high-quality care.

Throughout the inspection, the nominated individual acknowledged the concerns that we identified and told us of their plans to make improvements to ensure people received care that was safe and of high

quality. They were open and honest and engaged with CQC and other agencies to make improvement.

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

Rating at last inspection
The last rating for this service was good (published 14 November 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding incidents and a lack of leadership at Autism Hampshire - 102b Brockhurst Road. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Autism Hampshire – 102b Brockhurst Road on our website at www.cqc.org.uk.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, risk management, the premises, medicines management, staffing, person centred care and governance.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Autism Hampshire - 102b Brockhurst Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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
Two inspectors carried out the inspection.

Service Type
Autism Hampshire – 102b Brockhurst Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection, the registered manager was not working in the service. The service was being supported by an interim manager from another of the providers services and a senior manager.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed notifications the provider had sent us. Notifications are sent when a significant event has happened in the service. We used all of this information to plan our inspection.

During the inspection-
We carried out observations of people's experiences throughout the inspection. We spoke with one relative and received emailed feedback from another relative about their experience of the care provided. We spoke with nine members of staff including the interim manager, senior manager, senior care workers, care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received emailed feedback from three professionals about their experience of the service.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who regularly visits the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
• The provider did not have effective systems and processes to safeguard people from the risk of abuse.
• Staff told us the service was not safe and people were not protected against the risk of abuse. They felt this was in part due to the poor management of people's behaviours that caused concern and a lack of learning or action taken when safeguarding incidents occurred.
• Staff told us how one person physically and verbally abused other people in the home on a regular basis. They said this had been happening for months, but no action had been taken following these incidents. They felt the lack of action had resulted in an increased intensity and frequency of this abuse that put the person and others at risk of harm. At the time of our inspection, a staff member described the situation as "impossible".
• During our inspection, we observed a safeguarding incident between two people. Both people were at significant risk of harm during this. A staff member told us, "Whilst it was awful, I'm so glad you witnessed it, we've been telling management for months, but they haven't done anything. Hopefully, something will happen now."
• Staff told us that people's mental health had deteriorated due to the ongoing incidents of abuse. People were described as being "scared", "on edge" and displayed anxiety by "shaking" and "cowering".
• Staff had a satisfactory understanding of safeguarding and what constituted abuse. They told us they completed incident reports when a safeguarding incident had taken place but did not know what happened to them once they completed them. The nominated individual and service manager told us they had not always received the incident reports from the registered manager and were not aware of all safeguarding incidents. Therefore, safeguarding incidents were not always reported to CQC and the local authority safeguarding team to ensure appropriate action had been taken and people were kept safe. However, when the nominated individual and senior manager were aware of incidents, these were raised appropriately.
• People were not always supported in the least restrictive way possible. One person's food was locked in a cupboard and another person had a listening device in their room. There were no adequate records that demonstrated the principles of the Mental Capacity Act 2005 (MCA) had been followed. One person was under continuous control and supervision but did not have a deprivation of liberty safeguard (DoLS) applied for where required. This meant people's human rights were compromised.
• When we asked if people were safe, professionals feedback included, "Definitely not", "The safety at the house has managed to get to a point of significantly concerning." and "I do not feel the service is either well-led or safe at the present time."

The failure to safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

• During the inspection we told the local authority safeguarding team of our concerns. In conjunction with other professionals, measures were put in place and planned for to support safety in the service. We also told the nominated individual of our concerns. They additionally made arrangements to safeguard people. This meant the immediate risk of harm and abuse to people was reduced. Following the inspection, the nominated individual sent us an action plan. This detailed ongoing plans to ensure safeguarding concerns would be addressed.

Assessing risk, safety monitoring and management
• The inspection was in part, triggered by concerns about how people with complex needs and who behaved in a way that placed others at risk of harm were supported
• One person had a known behaviour that could result in physical and verbal aggression to staff and people living at 102b Brockhurst Road. They had a positive behaviour support plan (PBSP) in place which had been developed to guide staff on how best to monitor and reduce the risks associated with this person's behaviour. However, one staff member told us, "I've read them [PBSP's] but they are not very up to date, for example [Person's name] behaviours are changing all the time." And another staff member told us they had not had the opportunity to read this guidance. During our inspection, we observed staff did not follow the guidance in this person's PBSP when the person was at a heightened state of anxiety. The person became increasingly distressed and agitated which left the person and others at risk of serious harm.
• Another person also had known behaviours of concern. Their relative told us "If there's a change, it can cause anxiety for him but it's how you approach the change that makes a huge difference to how he copes." The relative and a professional had supported staff to implement strategies to reduce the risk of anxiety and behaviours that challenged others. However, these had not always been used by staff in the service. This meant the person behaved in a way that was challenging for staff to cope with. The lack of effective strategies to support this person left them and others at risk of harm.
• A third person had a PBSP in place. This stated that to reduce any known behaviours the person should be supported to watch television. However, at our inspection the person did not have access to a television. This meant the person's PBSP could not be followed which increased the risk of harm to people.
• Professionals told us that staff did not have the skills and knowledge to support people in a positive way. For example, one professional told us, "The team on the floor lacked a knowledge of Positive Behaviour Support. Whilst they clearly knew the term, they did not understand how to implement it and what to do with the basic knowledge they had." This meant risks associated with people's anxiety could not be safely managed.
• One person lived with a health condition. A risk assessment was in place which stated equipment should be used so staff could be alerted if the person experienced an episode associated with their health condition. However, this was not in place at the time of our inspection which increased the risk of harm for them.

The failure to do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During and following the inspection the nominated individual told us of their plans to ensure people were safely supported with risk management. A professional from the Clinical Commissioning Group (CCG) additionally implemented measures to help staff to understand how to safely support a person when their anxiety was heightened.

• There were a number of safety concerns in relation to the environment.
• Fire management was not safe. This included a lack of testing of firefighting equipment and portable

appliances. Fire doors were damaged and not all staff had received fire training or had taken part in drills. We referred our concerns to the fire service.
• Areas of the home were not clean, including the kitchen. Worksurfaces, cupboards, drawers and the fridge were dirty and had spillages that had dried on. Some food containers were open, uncovered and unlabelled, with some food being out of date. Due to the risk of harm this presented to people, we referred our concerns to the environmental health officer.
• The provider had not ensured regular cleaning had taken place which was evidenced by our observations and gaps in cleaning schedules. Communal areas were dusty with one room having stains on the walls and curtain. People's bedrooms and ensuite bathrooms were not clean. For example, one person's carpet was stained, another person's bedroom had food debris on the floor and rubbish down the side of their bed and a third person's bedsheets and mattress was stained. One person's bathroom had mould growing on the floor and on their personal belongings. The interim manager told us they had been "mortified" regarding the standard of cleaning in the home.
• The home was not well maintained which presented health and safety concerns. For example, one person's carpet was ripped, tiles were missing, work surfaces in the kitchen were chipped and the ceiling in the laundry was damaged.
• Not all aspects of the home were secure. For example, one person had a DoLS applied for and needed to be accompanied when going out of the home for their safety. A coded keypad was in place to prevent people at risk of harm from leaving on their own. However, this person knew the code and was seen by a professional to leave the home via this route. The side gate was additionally not secured. During our inspection, we observed this person to be outside and a staff member told us they thought the person had left through the gate. Cupboards that displayed signage stating 'keep locked' were not always locked. These included cupboards that contained chemicals. This put people at risk of harm.
• We observed that keys were left unattended in a cupboard which contained people's money. This meant people's money was not sufficiently protected.

The failure to ensure the premises was clean, properly maintained and secure was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During and after the inspection process, we raised our concerns with the nominated individual. They told us a refurbishment was due to be completed of the home and would ensure the premises were clean, safe and secure. In addition, a representative from the fire service and environmental health agreed to support the home.

Staffing and recruitment
• The provider had not ensured there were sufficient numbers of competent and skilled staff to support people safely.
• Staff told us there was not enough staff and attributed this to high staff turnover and sickness. Comments included, "Because of how intense it's been and lack of support, staff just don't want to do it [attend work] anymore. Staff members are scared to come in because they are getting attacked. The thought of coming into work is terrifying." and "They [provider] are hiring the wrong people. Staff come in and are just lazy, they haven't been told what the role is."
• One person expressed a preference to be supported by a particular group of staff. Due to the shortage of staff and the person's complex support needs, only two staff members felt able to work with this person. A professional from the CCG put arrangements in place for agency staff to support this person to ensure their safety.
• Some staff shortages had been covered by existing staff. However, this was not effectively managed. For example, one staff member told us, "I've worked 80 hours this week, I'm exhausted." Professionals told us of their concern regarding staff "burn out". One professional told us, "The staff on the ground are doing their

best but they are exhausted and burnt out, this is having an knock on effect for the people that are being supported by them." Following the inspection, the nominated individual told us they did not feel this was accurate. They had reviewed two staff members records and these demonstrated these staff had only worked 20 hours per month overtime.
• Other staff shortages were covered by agency staff. One agency staff member told us they had not received an induction into the home or been given information about the people they needed to support. Agency staff induction records could not be found during our inspection. This meant we were not assured people were being supported by staff in a safe and effective way.
• The inconsistency of the staff team meant people were not always supported by staff who knew them well or understood how best to meet their needs and ensure their safety. A relative told us of the importance of their relative being supported by staff who understood them well, in order to support their well-being.
• Staff told us that on some occasions, staff shortages could not be covered. This meant people could not always be supported with their chosen activities. One staff member told us, "It's not good for their [people's] mental health" and another staff member told us that personal care was sometimes rushed in these instances.
• We reviewed the training matrix and found not all training had been delivered for staff to be able to fulfil their role. This included first aid training and training to manage people's behaviours in a safe way. Staff confirmed this. When staff had received training, they did not always find it helpful. Comments provided to describe training included, "Farcical", "A tick box exercise" and "Rushed." One staff member additionally told us their induction into the home they would be working in was not effective. They said, "I got given an A4 sheet to tick off but [Person's name] was [displaying behaviours that were challenging] so I couldn't complete it. Everything I know has been through learning on the job. It's been really tough."
• "Professionals told us that staff were not sufficiently trained to support the people who lived in the home. For example, one professional told us, "I do not believe the staff have adequate training to support the complex needs of at least one of the service users. The staff team do not have the adequate skills to manage the challenging behaviours that can occur. I also feel they lack the skills required to support a person with Autism."

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

• During and following our inspection process, the nominated individual told us of their plans to ensure people were supported by sufficient numbers of suitably skilled and competent staff. They had already recognised that enhanced training was required and had begun to deliver this at the time of our inspection. Other training was planned for. They also put measures in place, so staff felt more supported. On the third day of our inspection a staff member told us of increased support they had received from the management team.
• The recruitment of staff was safe.

Using medicines safely
• Prior to our inspection, we were informed about a number of medicine errors in the service. During our inspection, we found medicines were not always managed safely.
• There were numerous gaps of recording on medication administration records (MARS). Numbers of tablets tallied with the recorded amount of stock which indicated people had received their tablets as prescribed. However, a lack of recording can increase the risk of error.
• Topical creams were not safely managed. For example, one person had two creams prescribed. Records demonstrated that one of these creams had not been applied. A staff member told us they thought it had been discontinued. However, the nominated individual later told us that it had not been. The other cream was out of date. Once the expiration date has passed there is no guarantee that the medicine will be safe

and effective. This meant the person's skin condition may not heal effectively because they were not having creams applied as prescribed.
• Some people had been prescribed medicines to be used as and when required (PRN). These medicines need PRN protocols to explain their use and how much to give, or when to use the medicine. One person did not have a PRN protocol in place. This meant they may not receive their medicines in the most effective way.

• Medicines should be stored at the correct temperature to ensure they are safe and effective. We found numerous gaps in temperature records. This meant we could not be assured that medicines were always stored in line with the manufacturer's instructions and therefore safe to use.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe medicines management. The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our inspection, the nominated individual sent us an action plan detailing how medicines would be managed safely.

Preventing and controlling infection
• As outlined in the 'Assessing risk, safety monitoring and management' section of the report, the provider was not promoting safety due to the lack of cleanliness and hygiene in the home.
• We were somewhat assured that the provider was preventing visitors from catching and spreading infections. We were asked for evidence of our COVID-19 status on two out of the three times we visited. Our temperature was taken but on the first day the thermometer appeared faulty. The nominated individual told us of their plans to ensure these practices were always safely managed.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was 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.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

• Systems and processes were not operated effectively to ensure the service was safe and people were receiving high-quality care. This led to multiple breaches of regulation and placed people at risk of harm as outlined in the safe domain of this report.

• The provider failed to operate effective systems to manage risk. For example, the service manager, interim manager and staff told us about safety concerns and a high number of safeguarding incidents which placed people and staff at risk of harm. However, safeguarding incidents had not been investigated, analysed or acted upon effectively to inform ongoing practice and ensure people's safety. On the first day of our inspection, we observed an incident where two people were at significant risk of harm. This demonstrated the systems to manage risks had been ineffective.

• The provider failed to follow their own governance policy to ensure quality and safety. Some audits were carried out, but these were not done in line with their policy because they were not completed consistently or effectively. For example, infection control audits had not been completed between April and September 2021. When medication audits had been completed, they did not drive improvement. For example, gaps on MARs had been highlighted in most of the audits but no action was taken, and gaps were identified during our inspection.

• The provider used an overarching quality audit which incorporated all aspects of service delivery. This consisted of assessment, action and review. The initial assessment had been undertaken by the registered manager in February 2021 and reviewed by a quality manager in April 2021. This identified a number of shortfalls at 102b Brockhurst Road, including gaps in MARs, unclean areas in the home and people's risk management plans not being completed. This was reviewed in October 2021 and action had not been taken to address all of the previously identified issues. Furthermore, deterioration in the service was identified. We found most of these issues were still ongoing at the time of our inspection. This demonstrated the system had not been effective in ensuring the service was safe, people received high-quality care or drove necessary improvement where concerns were identified.

• External agencies had visited the home to complete audits. However, this also did not drive the provider to make necessary improvements. For example, we found some of the same issues at our inspection that was identified in a health and safety audit in May 2021 and in an environmental health review in 2019.

• Other action was not taken when needed. For example, on the first day of our inspection we highlighted issues to the nominated individual and senior staff, some of which could have been promptly rectified.

However, no action was taken. For example, we noted a cupboard was left unlocked which contained chemicals on the first day of our inspection. On the second and third day of our inspection, it was still unlocked, and people continued to be placed at the risk of avoidable harm.
• The provider failed to ensure records were accurate and up to date. For example, we noted care plans contained out of date information which was meant staff did not have easily accessible current information about people. Records relating to the management of the home were additionally incomplete. These included cleaning schedules, fire monitoring records and medication storage temperature records. One staff member told us, "Paperwork is so out of place. No one quite knows what goes where."
• The nominated individual told us about the leadership arrangements in the service. This included a senior manager, two registered managers, support managers and positive behaviour support leads who were supporting the service at various times between April and November 2021. However, these arrangements did not ensure the delivery of high-quality care. Relatives, staff and professionals told us the service was not well-led. Comments included, "My confidence in the leadership is at an all-time low.", "The support from managers is non-existent." And "The home is definitely not well-led. A lack of leadership is the main problem."
• Staff told us that the lack of leadership meant they were not always clear of their role. For example, one member of staff told us they were not fulfilling the requirements of their job description because they had not been shown how. Another said they had been undertaking a role above their pay grade and a third told us that work was not shared fairly. The lack of leadership meant staff did not always work as a team or well together. One staff member said, "There's no team spirit." Staff additionally told us performance issues were not sufficiently dealt with, meaning poor practice continued.
• At the time of our inspection the registered manager was not working in the service. Staff told us the registered manager had not been able to fulfil their role and ensure the quality and safety of the home for some time. The provider had not checked to ensure the registered manager was fulfilling the requirements of their role in a timely way. The lack of leadership, direction and oversight led to significant deterioration and shortfalls in the service.

The failure to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks and maintain accurate and complete records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the first day of our inspection, the nominated individual and senior manager put measures in place to ensure staff felt more supported. Most staff told us the support they received was helpful and supported their well-being.
• The nominated individual additionally sent us an action plan detailing how they would improve the governance of the home. They told us that a new manager and deputy manager would provide effective leadership and have sufficient oversight from the provider. The action plan also detailed how quality assurance processes would be strengthened.
• The previous performance rating was displayed within the home and on the providers website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control and independence over their lives. Care was not person-centred and the poor leadership by the provider did not ensure people led empowered lives. One professional told us, "They [people] exist, they don't live."
• People did not always receive person-centred care. This was partly because staff lacked knowledge about people due to being new to the service or a lack of support and training. A professional told us about one person who required particular support to minimise their anxieties. This had previously been successful, and

the person had been settled in the home. However, over time, staff who had learnt these techniques and strategies had left and new staff had not been provided with this information. This meant the person's anxieties increased and behaved in a way that staff and other people in the house found challenging.
• A professional, a relative and staff told us there was a clash of personalities between two people in the home. This further increased anxieties and impacted everyone. Staff told us that one person was constantly on edge whilst another was scared. This meant people had not been supported to make a choice about who they lived with or felt safe and happy in their own homes.
• The time staff were required to spend supporting people's heightened anxieties meant time was reduced on undertaking personalised and meaningful activities to enhance well-being. For example, one staff member told us, "[Person's name] hasn't been given enough looking after, everyone's [staff] too busy worrying about [Person's name] behaviour so [Person's name] has been left out in the cold." Another staff member agreed and told us, "[Person's name] has been really neglected, he's always put last."
• People were not always supported to feel empowered. For example, we observed whenever one person wanted to do something such as have a bath or go for a walk, staff would use a timer, so they needed to wait. Staff were not able to provide a satisfactory rationale of why this practice was in place. We observed the person pacing whilst waiting for the timer which indicated anxiety. Although a staff member told us, "The poor man is made to wait", no one had raised this as an issue to be resolved. This demonstrated a poor culture and one that did not promote independence or person-centred care.

The failure to provide people with person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us that morale in the home was low. They mainly attributed this to the lack of support they received. Comments included, "It's been appalling, a couple of times I wanted to hand my notice in. There's a massive lack of support.", "I get support from other support workers, from managers it's non-existent." And "We may as well not have any [senior leaders] for as much use they've been."
• Staff had raised concerns for their own safety whilst supporting some people. Staff members told us they were expected to put themselves in situations that compromised their safety such as travelling on public transport whilst supporting a person at night. Staff additionally told us they had been harmed by people but were still directed to take people out on a one to one basis. For example, one staff member said, "Young girls [staff] shouldn't be going out on their own with [Person's name] late at night. It's not safe for [Person's name] and it's not safe for the staff." This practice stopped following the first day of our inspection.
• Some staff members told us they had considered leaving but had stayed because they cared about the people they supported. For example, one staff member said, "I'm still here because of the guys, I don't feel comfortable enough to move on. At least I know when I'm here they are getting what they need."
• The nominated individual told us about measures in place to support staff to raise concerns. These included, staff forums, a staff survey and information about how to share concerns with the nominated individual. However, staff did not share information about these processes or how these supported them. This meant these systems were ineffective.
• At times, we identified a lack of accountability regarding the shortfalls in the service. A professional told us, "I felt a real blame culture was present. It always seemed to be someone else's fault. Almost everyone I spoke to blamed someone else."
• There were several indicators of closed cultures within the service. For example, the service supported people who were less able to speak up for themselves without good support from the service. People had not been safeguarded against harm and abuse and the principles of the MCA had not always been followed. Staff turnover was high, a lack of suitable induction and training was identified, and staff told us they worked excessively long hours. The governance of the service was poor, and staff felt unsupported. The provider had recognised some of the cultural issues in the home following a whistle-blowing concern in July 2021. Action had begun and a cultural review had taken place. However, insufficient action to mitigate the risk of these

indicators of a closed culture left people in receipt of poor-quality care.
• Throughout our inspection process, the nominated individual acted in a transparent way and told us they would do all they could to ensure the culture of the service improved. They sent us an action plan detailing their plans of doing this. The staff we spoke with additionally demonstrated genuine care for the people they supported and were keen for the service to improve.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others
• There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home. We asked a staff member whether people were supported to make decisions about their care, and they replied, "No."
• Relatives told us they did not feel engaged by the provider. They felt their views were not sought about the planning of their day to day care or the running of the service. One relative told us, "A lot of the strategies that have been put in place have been led by me. It's rare there has been someone at 102b who can take it on board." And another relative said, "Autism Hampshire seem to have stopped communicating with us over the past couple of months since the departure of [staff member's name] and we have been left rather in the dark as to what has been going on in the home."
• Staff told us they did not always feel valued or listened to. Staff did not have access to regular supervision and team meetings. Staff told us of examples where they had raised concerns about feeling unsafe and the management of people's behaviours but felt these concerns had not been taken on board and no action had been taken. One member of staff told us about a time they had raised concerns to a previous senior manager, and this was not kept confidential. This resulted in the staff member feeling unable to raise further concerns as it made their working life difficult.
• The provider had failed to recognise or investigate incidents to prevent reoccurrences and failed to communicate to professionals and families when incidents had occurred.
• Professionals told us the provider did not always work in partnership with them. One professional told us, "I was trying to implement things, but they fell on deaf ears. If I suggested some equipment, I would be told, no."

The failure to seek and act on feedback was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the nominated individual had planned to meet stakeholders to address some of the concerns that had been identified. They also sent us an action plan detailing how they would improve partnership working.
• Records demonstrated that staff contacted professionals to support people with their health needs when required.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider did not have a duty of candour policy in place. This meant guidance about how to meet the duty of candour was not available to staff. The senior manager was not able to demonstrate a full understanding of how to meet this regulation. However, they went on to tell us there was a lack of transparency when things went wrong.

We recommend the provider seeks guidance from a reputable source to ensure the duty of candour regulation is met.

• During the inspection the nominated individual, senior manager, interim manager and staff were open and honest with the inspectors.