Strode Park Foundation For People With Disabilities

The Coach House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Coach House is a residential care home providing personal and nursing care to up to nine people. Although The Coach House is registered to provide nursing care the service does not provide this at present, and people requiring nursing care have been cared for in their sister service on the same site. The service provides support to people with a learning disability, autistic people, people with a physical disability, people with a sensory impairment and younger adults. At the time of our inspection there were eight people using the service. People are cared for in one adapted building with bedrooms over two floors, and each bedroom has en-suite facilities.

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

Right Support:
The Coach House was in a campus site with other services and this does not meet the Right support, right, care, right culture guidance. People did not go off the campus site very often and some people were being restricted in what time they went to bed by staff availability. There was not a wide range of activities on offer for people and activities were often not available to people because there were not enough staff to support them.

People were not consistently supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The provider had in place policies to supported best practice but these were not being consistently adhered to.

We have made a recommendation about the application of the Mental Capacity Act 2005.

Right Care:
The service did not always have enough appropriately skilled staff to meet people's needs and to keep them safe. Staff told us they could not take people out as much as people wanted to go out. Some people were not being supported to be as independent as they could be with activities of daily living and some people's communication was not being supported in a person-centred way.
Individual staff were caring and treated people with kindness.

Right Culture:
People did not always receive safe and good quality care. For example, people with epilepsy and

constipation did not always receive their assessed care and support due to staff not having the correct skills, training or guidance.
The culture of the service was not always person centred. Some people did not have care plans and support that reflected their needs. Audits had not been effective in identifying and putting right shortfalls in the service.

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 15 September 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and medicines management in the service. A decision was made for us to inspect earlier than planned to examine those risks.

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.

You can see what action we have asked the provider to take at the end 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 monitor the service and will take further action if needed.

We have identified breaches in relation to managing medicines and people's specific health risks safely, sufficient and suitable staffing levels, person centred care and the overall management of the service at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Coach 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.

Inspection team
The inspection was carried out by two inspectors and two medicines inspectors.

Service and service type
The Coach 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. The Coach House is a care home currently without 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.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 September 2022 and ended on 10 October 2022. We visited the service on 13 and 15 September 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). 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 used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with seven staff including the registered manager, senior support staff, carers and the cook. We reviewed a range of records. This included four people's care records, including medicine records. We looked at four staff files in relation to recruitment, and a variety of records relating to the management of 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.

At our last inspection we rated this key question Good. At this inspection the rating has changed 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

- Systems and processes had not consistently protected people from abuse. Incidents had not always been reported to the local authority safeguarding adults team. Staff had recorded some incidents in care notes and others in incident reports and the registered manager had not consistently escalated these to local safeguarding teams.
- We found incidents where people had been involved in physical altercations with other people. Systems had not been effective in ensuring these were reported correctly. This left people at risk of repeated incidents.
- We reported two incidents to the local authority safeguarding adults team that had not been reported by the provider. Failing to report incidents puts people at risk of repeat distress or harm, prevents independent oversight of them and does not give people the opportunity to have their voice heard about the incidents.

Due to systems not identifying all safeguarding incidents people were at risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Some people living at The Coach House were diagnosed with epilepsy and required medicines, including rescue medicines when they experienced a prolonged seizure. However, these were not always administered as assessed. One person was assessed as needing emergency services to be called after having their rescue medicine, but this did not happen as set out in care documents. Staff called 111 instead of 999 and a paramedic was dispatched by the call handler.
- The same person then had a prolonged seizure during our inspection but was not given their rescue medicine. Staff should have ensured the rescue medicine was ready to be administered at the point a seizure lasted five minutes. However, staff had waited five minutes from the start of the seizure, before going to tell a trained staff the person need their rescue medicine. By the time the medicine was ready to be administered more than seven minutes had elapsed, and the seizure was finished. This meant the person suffered a longer seizure than necessary.
- People were not being protected from the risks of choking. One person had a choking incident in July 2022. However, there had been no update to their choking risk assessment or care plans. The person had been hospitalised previously on two occasions for infection of the airway and lungs. Despite this no referral was made to the speech and language therapy team following the choking incident. The person's choking risk assessment did not consider practical measures related to that person, such as how to perform back slaps if they were in a wheelchair. We raised this with the provider on the day of our inspection and the risk was reassessed.

● Some people living at The Coach House experienced anxiety and required positive behaviour support. One person had a care plan for managing their anxieties that stated they might grab staff but did not plan how staff should respond. The same person had a different risk assessment that stated they could try and hurt staff during a specific task. However, there was no plan for what to do and this was not explored in the care plan for positive behaviour support. This put the person, their staff and other people at risk.

Learning lessons when things go wrong

● Lessons were not being learned or systems improved consistently when things went wrong. When things went wrong staff were expected to complete an incident form and this would then be reviewed by managers so that learning could be shared with the staff team. However, we found incidents in daily notes and emotional support notes where no incident form had been completed and there had been no formal review.

● One person had been involved in an incident with other people they lived with but there was no incident report completed. The person had been involved in previous episodes where their anxieties caused them to experience difficulties. However, there was no positive behaviour plan for them and guidance had not been implemented or reviewed to inform staff how to better support the person should the incident re-occur

● A second person also had an incident around a seizure and no incident form was completed. This meant staff did not learn from the first incident and mistakes were made by staff when the person had subsequent seizures. This put people at risk of not receiving safe care and support. Additionally, an accurate record of seizures was not then kept to inform healthcare professionals in reviews.

Using medicines safely

● Medicines were not being safely managed at The Coach House. Some people were prescribed 'as required' medicines. These medicines did not have a protocol for their use. As a result, staff were deciding without formal guidance when to give people medicines to relieve their constipation. One staff told us, "The guideline [on when to give the medicine] is when we think it's necessary." One person went almost seven days without a bowel movement despite having suppositories prescribed to be given on the fifth day, that were not administered. This meant people sometimes went longer than necessary before receiving their medicines.

● Medicines administration and supporting documents consistently contained errors. These related to spelling of medicine names and the strength and dose of a medicine. There was no process in place to ensure this information was being recorded accurately.

● People's preferences on how they wanted staff to support them with their medicines was not always available at the point of administration. Medicines care plans were not always available or in place. These were not always reviewed or updated regularly.

● There was not a robust process in place to ensure that medicines were stored in line with legal or manufacturers' requirements. This included the monitoring of temperatures in places where medicines were or could be stored. We also found that the controlled drugs cabinet was not secured in line with legal requirements and had been taken off the wall so it could be picked up and removed. Following our site visit the provider resolved this.

Due to poor risk management of people's conditions and medicines people were placed at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was not sufficient staffing to meet people's needs. One person was assessed as requiring physiotherapy exercises. We could not see these exercises were happening so asked one staff who told us,

"(Person) does have exercises, but not regularly as you need two staff."

● There was only one staff working at night-time and some people required two staff to be able to change their incontinence pads. We were told that night staff called for assistance from a different service on the same site. However, we found instances where this did not happen. For example, in June one person's pressure mattress deflated but the other service was unable to send a staff, so the person was left laying on towels until morning staff arrived. This left the person at risk to their skin breaking down.

● People did not have enough staff to do the things they wanted to. For example, one person had an emotional support note written in their care notes because they were very unhappy about staffing levels, were crying and did not have their one to one staff.

● Another person spoke with us about how they were upset they couldn't go out for lunch after their weekly appointment because of staffing levels. One staff we spoke with told us of their frustrations around not being able to take people out when they wanted to go out. The staff said, "I just want to take people out and support them, but it's really difficult with no staff." We spoke with the provider about the high level of vacancies and the provider had a plan to recruit more staff.

Due to lack of staffing people's needs were not being met. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been safely recruited and staff files contained ID checks, interview notes, two references and all staff had received enhanced DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. During the first day of our inspection staff were not wearing face masks against government directives. We raised this with the registered manager who had been advised by a director that staff no longer needed to wear masks. When we shared the latest guidance, the registered manager ensured all staff were wearing masks.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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 free to have visitors to their home without restrictions.

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 Good. At this inspection the rating has changed to Requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People did not always have the support to live healthy lives. Some people living at The Coach House needed support to complete physiotherapy exercises. One person had been assessed as needing a special treatment three times a week when they were well and twice daily when unwell. This was not being recorded and staff confirmed they were not doing the exercises. In place of the assessed exercise a vibrating cushion had been used, but there was no information explaining why this was being used. Following our inspection, the provider rereferred the person back to the physiotherapist.
- Some people had been advised by their dentists to use a special prescription toothpaste. However, when we checked two people's rooms, they did not have this and had over the counter generic toothpaste instead.
- People with a learning disability are more prone to experience problems with constipation. People's constipation needs were not being managed well. People with medicines prescribed for constipation had care plans for bowel health but these did not set out how to safely manage constipation for each person.
- People diagnosed with epilepsy were not having their seizures effectively monitored. There were video monitors that showed staff people in their bedrooms on a small screen. There were four video and audio monitors but only one night staff and the monitors could not be next to each other as there was signal interference. One staff told us, "We do have monitors but it's very difficult to monitor and the signal is bad, you have lots of chores to do. We don't stop during a wake night." This meant seizure monitoring was not safe. We raised this with the provider who ordered and installed a new monitoring system.

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

- People's weights were not being safely monitored or managed. One person had previously been referred for specialist help for their weight loss and was prescribed supplements. However, the person was currently at a lower weight than when they previously had supplements, but no referral had been made.
- A second person had been weighed regularly and these weights showed they had lost approximately a stone. There had been no referral to a dietician. The service had been offering extra snacks but their weight loss had not been discussed with the GP and there was no specialist malnutrition screening tool in place that other people were using. This left people at risk of poor health.
- Another person had a prescribed drink to supplement their nutritional intake. However, this was not being monitored closely and should have been recorded on a medicines chart. We raised this with the provider and they took action during our inspection.
- One person had a behaviour and wellbeing plan that set out how the person needed to be seated when eating to ensure they ate and drank well. However, during our inspection we saw this was not adhered to.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

● People had preadmission assessments completed prior to being accepted at the service. However, these were lacking in specific detail around areas such as communication and managing people's anxieties. For example, stating a person need encouragement to eat but not setting out specifically how that should be done.

● The provider was sometimes using evidence-based guidance to ensure people had effective outcomes. People at risk of skin breakdown had a Waterlow assessment. This is a tool for assessing the level of risk of a person developing a pressure wound. However, the provider's care plan audit stated these should be re-assessed every three months but this was only happening yearly. This left people a risk of developing health issues relating to their skin.

● It was not consistently clear that assessments of people's physical, mental, and social needs led to effective support outcomes. People's needs were not always identified in care plans and staff gave us varying information when speaking about people's conditions. We have reported on this in more detail in the Safe section of this report.

● The registered manager had been working with the provider's in-house health teams and the local health team. However, there was not a clear understanding between the provider and commissioners about the level of support being funded. This meant people's support needs were sometimes not met.

Due to poor management of health conditions, nutrition, and assessments people were at risk of not receiving effective care. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Some staff training was out of date or had not been completed. 15 percent of staff had safeguarding training that had expired. Other training courses had been well attended by staff.

● Staff supervisions were not happening with the frequency the registered manager wanted. We checked staff files and most staff had received one supervision but the registered manager told us that the frequency of supervisions had been impacted by staff shortages.

● One staff who worked regular lone night shifts had not been trained in medicines administration. There was a risk that if people needed PRN medicines, such as pain relief or for anxiety, to be administered in the night-time there would be a delay in them receiving their medicines as they would need to wait for staff to come from another service.

Due to concerns around staffing in some key areas such as supervision people were at risk of poor support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had access to a range of training courses and staff had completed other training to a good level.

● The service had recently appointed a cook and people told us the food had improved. The cook told us, "I've done extra training: I had food and hygiene like the carers, I feel supported by management definitely, I go in (to see the manager) if I have any problems."

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 had MCA assessments completed for decisions around their care where they were deemed to lack capacity. However, we found some decisions for people's care that had not been assessed under the MCA. For example, people with epilepsy had video monitors recording them in bed. People unable to consent to this had not had the decision made under the MCA to ensure it was the least restrictive option. Following our inspection, a different epilepsy monitoring system was installed that was less restrictive.
- People had DoLS in place where they were appropriate and necessary. When these had expired staff had ensured an application to reapply was made.

We recommend the registered provider considers latest guidance on meeting the MCA 2005 and reviews their practice accordingly.

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

- The service was based in a campus setting and although the grounds were pleasant and accessible this does not meet the current government guidance on services for people with a learning disability and autistic people.
- People were able to decorate their bedrooms and have their own furniture. People's bedrooms reflected their unique tastes and styles.
- The Coach House had its' own accessible garden and people used this regularly.

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 Good. At this inspection the rating has changed to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not being supported to be as independent as possible with some aspects of daily living. We spoke with the registered manager who told us, "It's fallen to the wayside at the moment. Just taking (people) on the bus to pay for their own fare and pay for things at the shops but it's not happening as we haven't got staff to facilitate that…they haven't had additional stuff we're good at like helping them cook dinner, or helping them buy food."
- We asked staff about how they supported people to achieve independence. One staff said, "Usually we encourage them to do things on their own, like brushing teeth and supervise them." However, there was a lack of opportunity for people to use their skills, or learn new skills, such as cooking.

Supporting people to express their views and be involved in making decisions about their care
- People were not being consistently supported to communicate their views. One person used a device to help them communicate. When we spoke with the person staff were unaware the device was working and it had not been charged, so was on a very low battery meaning the person could not speak with us for long.
- Care plans were not always being reviewed with people. Where care plans were reviewed, they frequently stated 'no change'. However, we found several areas where care plans were lacking in specific detail or did not reflect people's needs, such as around managing anxiety or constipation.

Due to lack of independence and communication support people were not receiving person-centred support. The provider failed to ensure care was designed to meet people's needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
- Staff treated people with kindness and were caring. We observed several kind interactions between staff and people.
- Staff were patient with people and gave them time to express themselves. One person with communication difficulties was given lots of time to ask a question of one staff. Other people were given time to finish a drink or complete a task.
- Permanent staff knew people's needs well. One staff told us of one person, "(Person) will fling their arms up if the music or environment is too loud, then I will take them somewhere quieter."
- Staff told us about two different people who have teddy bears and how they use these in different ways to let staff know their needs.

● Staff were respectful of people in their interactions. For example, one staff ensured they got a person's permission to speak with us about different things that had happened to them. Every time the conversation changed staff checked with the person it was ok to share the information with us.

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 Good. At this inspection the rating has changed to Requires improvement. This meant people's needs were not always met.

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

●People were not consistently supported to take part in activities that were important to them which would enable them to develop new relationships. However, people were supported to maintain relationships with friends and family.

●We reviewed people's activities provision and found that people were not going out very often despite wanting to.

● One person had only been off the campus site once in the three months prior to our inspection, for a family visit. The same person had recently spoken in a key worker meeting about the activities they enjoyed and would like to do. Activities included swimming which they appeared to benefit from and enjoy, going out and about for drives, for seaside walks and eating out. They also enjoyed sensory activities that engaged them. However, none of these activities were being provided.

● Other people we reviewed over a three-month period also rarely left the campus and activities were repetitive and poor. For example, another person went out for a meal twice, shopping once and a drive in three months. Staff told us they couldn't take people out due to staffing and people got upset at the lack of outings and activities.

● Care plans lacked information about people's preferences, aspirations and life history. Goals in care plans were practical such as avoid pain when mobilising, rather than achieving personal goals such as getting a job or trying new activities.

●Following our site visit the provider told us that Covid and local recruitment challenges had meant they had not been able to support people with off-site activities at levels previously provided.

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

● Two people who needed two staff to support them with a hoist were not able to choose their bedtime and were unable to go out for evening activities. Staff told us the two people needed to be in bed by a certain time, as there would not be enough staff to support them to go to bed. One staff said, "They have to be in bed by 10 if they need hoisting. Nobody goes out in evening; no client gets out and doors are locked." This meant people were in bed often before 9pm.

● People did not always receive personalised care to meet their need and preferences. One person was assessed during a DoLS application and it was recommended the service reviewed the person's support to try a wider variety of activities particularly during one to one support and record the persons response. However, during our inspection we were told the person no longer had access to one to one support and we saw their activities were limited.

● People's care plans did not consistently reflect their support needs. For example, one person had been

recorded as experiencing anxieties that led to staff recording incidents in an emotional support chart. However, the person did not have a positive behaviour support plan for staff to follow. This left the person at risk of repeat distress.

Due to poor activities provision and care planning people did not receive person centred support. This was a breach of regulation 9 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.
● People with communication aids did not always receive consistent support to use these. One person with a device did not have this charged and their staff was unaware it was not working. We have reported on this in the Caring section of this report.
● People's care and support plans detailed how people preferred to communicate, but these were not always reviewed in a timely way. For example, one person's care plan stated they were in the process of being assessed for a communication device in June 2020 but had not been updated with progress since then.
● Staff understood how two people communicated by using personal objects that were important to them. Staff explained this to us, and how each person communicated in a different way with their chosen objects.

Improving care quality in response to complaints or concerns
● There was a complaints log that captured each complaint and its resolution. Complaints were resolved in line with the provider's complaints policy.
● However, where we saw that people had been unhappy, there was no record of staff supporting them to make a complaint. For example, when people had been recorded as being upset, they were unable to attend activities due to lack of staffing or one to one support.

End of life care and support
● Nobody at The Coach House was receiving end of life care. Some people had informed the provider which funeral directors they wished to use.
● We spoke with the registered manager about end of life care and was told, "I've had one death in 20 plus years and that was not planned or expected." The registered manager explained that people who required planned end of life care would be moved somewhere that could provide this.
● People did not have end of life care plans. The registered manager said that they had spoken with some people's parents but they were not ready to discuss this yet.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

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

- There had been a significant deterioration in the overall quality of the service since our previous inspection. Our inspection found concerns with the management of risk, medicines, staffing allocations, management of some health needs, person-centred care, activities, culture and the campus style setting of the service.
- Despite the widespread concerns outlined above, the registered provider had not ensured that audits were happening with the planned frequency, and audits were not effective in highlighting concerns or putting them right. There was a lack of knowledge around IPC guidelines, and best practice around the specific risks to people with a learning disability, such as constipation and epilepsy.
- Some audits had not been happening regularly; for example, a monthly falls audit had last been completed at the start of March. A monthly service audit was last completed in June.
- A care plans and assessments audit showed Waterlow assessments should be every two to three months but had been last done five months prior to the audit. The same audit also commented that, "There is evidence that documents are reviewed on a regular basis, however, no evidence that they are reactions to events and some are out of date." This comment from the audit was made in August 2022. However, we found the same concerns at this inspection.
- We found some care plans were not accurate, such as one person's sleeping care plan stating they had an epilepsy sensor mat when they didn't have this, or people's constipation care plans not having the information staff needed to know when to take action.
- We asked the registered manager why issues including epilepsy monitoring, constipation, medicines management, choking risk management and staffing had not been resolved prior to our inspection. The registered manager said, "We found transferring from original paper files to (electronic system) some information was historical and wasn't maintained and reviewed. We haven't got same staff numbers to watch people and time seizures and perhaps lost the thread of that a bit," The registered manager also said the lead carers roles had reduced from four to two, following staff leaving, which had an impact on the service. The provider was recruiting to these lead roles.
- The manager understood the need to send CQC notifications when significant events occurred. However, some incidents had not been reported correctly so notifications were not sent.

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

- We found that there was not a person-centred culture at the service. People were not able to attend to

social events as they wished due to lack of staffing or rota management. Accidents and incidents were not being consistently recorded or reported.
● The provider had failed to identify and put right shortfalls regarding records for people's specific health needs, such as constipation and epilepsy. People's care plans and risk assessments were not up to date or reflected people's current needs. Guidance was not always in place for staff regarding people's medicines.
● Governance processes had not ensured people were kept safe or that people received good quality care and support. The provider had failed to maintain their good rating from the last inspection.

Due to a lack of effective auditing and governance people were at risk from poor care. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our site visit the provider had sent an action plan outlining the areas they were working towards, including increased audits and fully implementing new care plan and medicines management systems. The provider had been working to recruit staff using values-based recruitment, and staff referral and retention bonuses. The provider had also supported some staff to progress from support roles to management roles.

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 understood their legal duty regarding duty of candour. Where incidents had been reported, people's relatives were informed. However, there were also incidents that had not been reported correctly, so people's families may not know about these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff had been active in suggesting ways to improve support for people at The Coach House. The registered manager gave an example of people being supported on holidays.
● People had been actively involved in interviewing staff and the registered manager told us about a question one person had asked prospective candidates. Where people were not comfortable with interviewees, their opinions were listened to and those prospective staff were not offered jobs.
● There were some links with the local community such as specialist discos for people with a learning disability. Three people had worked as part of a scheme via a local college where they were paid for teaching professionals what it was like to have a learning disability. However, people's ability to access their community was not being supported well. We have reported on this more in the Responsive section of this report.

Working in partnership with others
● People had been referred to specialist health teams when necessary. The manager told us that following a choking incident one person was re-referred to the local speech and language therapy team.
● People's confidential information had been shared safely and securely. The registered manager told us they had an NHS email account and the provider had a confidential system with a passcode and email to ensure people's personal data was protected.