Centurion Health Care Limited

Penley View

Inspection report

Marlow Road
Stokenchurch
High Wycombe
Buckinghamshire
HP14 3UW

Tel: 01494482139

Date of inspection visit:
25 February 2022
28 February 2022
01 March 2022
15 March 2022

Date of publication:
01 March 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Penley View is a residential care home providing personal care and accommodation to up to six people. The service provides support to adults with a learning disability, autism, dementia, mental health conditions, physical disabilities and sensory impairments. At the time of our inspection there were six people using the service in one purpose-built unit, which is adjoined to a separately registered care home operated by the same care provider. One person left the service after the first day of our inspection and another person was admitted to hospital after our third onsite visit.

People's experience of using this service and what we found
People did not always live safely or free from unwarranted restrictions because the service did not assess, monitor or manage people's safety well. The service did not work well with other agencies to protect people from the risk of abuse.

The skills of staff did not match the needs of people using the service. Records were not in place to demonstrate the correct level of staffing was planned and delivered. Staff recruitment and induction training processes did not promote safety, including those for agency staff. Staff were not always familiar with people needs or risks.

Relatives told us they experienced staff who were generally helpful and caring although they felt staff language barriers impacted people's care and effective communication. During our inspection we found the service had identified one member of staff's English language needed to improve, however, there was no development plan in place to support this.

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 best practice.

Staff did not complete functional assessments for people who needed them to understand people's behaviours. Care and support plans were not holistic, strengths-based and did not capture people's needs and aspirations.

People's relatives felt they were kept informed of changes to their family members needs and were involved in reviews of people's plans. Records showed the service did not always consult people's relatives about unexplained injuries.

Staff members did not always treat people with warmth, dignity and respect when interacting with people. People were not supported to express their views using their preferred method of communication.

Systems were not established to capture and respond to complaints and gather feedback to improve the

service. Governance processes were not effective to hold staff to account, keep people safe, protect people's rights or provide good quality care and support

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support
The service did not plan effectively with people for when they experienced periods of distress. This meant alternatives were not always explored to ensure people's freedoms were restricted as a last resort. Staff were not supported to learn from incidents and how they might be avoided or reduced.

Right care
People did not always receive kind and compassionate care. Staff did not take action to protect and respect people's privacy and dignity. The service failed to ensure there were enough appropriately skilled staff to meet people's needs and keep them safe.

Right culture
The service failed to evaluate the quality of support provided to people or ensure risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity.

The provider took immediate action to seek external support to address leadership and governance concerns and implemented an urgent action plan to mitigate risks to people's safety and quality of life. For example, the provider purchased and started to launch new policies within two weeks of our site visit.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 5 May 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider considers current guidance on the safe recording of medicines and the accessible information standard and act to update their practice in these areas. At this inspection we found the provider had not acted on recommendations and improvements had not been made.

Why we inspected
The inspection was prompted in part due to safeguarding concerns received about nutrition, delayed medical intervention and staff interactions towards a person. We also received concerns about poor management oversight, staffing levels and staff training. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of a specific incident. Following which a person

using the service sustained a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of accidents and incidents and seeking timely medical interventions. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Penley View on our website at www.cqc.org.uk.

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 identified breaches in relation to safe care, safeguarding from abuse, person centred care, dignity and respect, staffing levels and suitability, nutrition and hydration, suitability of the environment, management of complaints, staff training, governance and leadership, reporting of incidents and duty of candour at this inspection.

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

We took enforcement action to cancel the manager's registration. Other action we proposed was withdrawn in response to improvements found at a further inspection.

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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not 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.

Penley View

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by one inspector, one inspection manager and a medicines inspector. An Expert by Experience made telephone calls to people's relatives to gain their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Penley View 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. Penley View is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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 our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 25 February 2022 and ended on 15 March 2022. We visited the service on 25 and 28 February 2022 and 1 and 3 March 2022. We gathered further information in a remote meeting with the provider on 15 March 2022 and continued to seek electronic information until 29 March 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 communicated with one person who used the service using key words, Makaton sign language and gestures. We spoke with seven relatives (of five people who used the service) about their experience of the care provided. We spent time observing people who could not talk with us.

We spoke with eleven members of staff including the provider, registered manager, manager, operations manager, team leader, care workers and two nominated individuals (NI). The nominated individual is responsible for supervising the management of the service on behalf of the provider. After our site inspection visits the nominated individual, who was also the owner, resigned from the position of NI and employed a new NI.

During our inspection we received online feedback from three staff members. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment checks and two agency staff profiles. 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, staff rotas and quality assurance records. We spoke with two professionals who were involved with people care and attended meetings with local authority and clinical commissioning group health and social care professionals to monitor people's safety.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure systems were in place and robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Staff practice put people at increased risk of harm. We observed a staff member use a technique to move and position a person which was not agreed as part of their risk assessment and did not consider their shoulder injury. The person's care plan and risk assessment had not been updated to reflect the person's shoulder injury or how staff should support the person to mitigate risk.
• Records showed the service delayed seeking appropriate medical attention for two people in response to injuries. Staff failed to take another person to the correct hospital as part of their emergency plan, which delayed treatment. We were concerned this put people's health and wellbeing at increased risk.
• An agency staff member told us they left a person unsupervised in the shower. This was against the person's care plan and epilepsy risk assessment, which stated the person needed staff support and supervision to shower, dry and dress.
• Another person's eating and drinking risk assessment did not identify or mitigate hazards associated with their nutritional care plan.
• The registered manager told us the same person required two staff to access the community as the person could "kick out" at staff. This was not included in the risk assessment and there was no information about why this level of support was needed, or how staff were to manage any safety issues.
• Effective health and safety procedures were either not established or implemented by staff to promote people's safety. Two of the three night staff members we spoke with did not know the fire evacuation procedure. No fire drills were completed to simulate reduced staffing, people's responses at night or how people would be safely supported once evacuated. An agency staff member told us if they could not move people, they would lock them in their bedrooms for the fire service to rescue. Locking service users in their bedrooms would be unsafe and was not in accordance with their personal emergency evacuation plans (PEEPs). However, PEEPs did state if service users refused to leave the building, they should be left in their bedroom with the door shut. There was limited guidance about how staff could encourage service users to evacuate and there was no consideration or risk assessment about whether physical intervention would be appropriate to maintain their safety in such an emergency.
• We found house keys were not secure. For example, keys to the patio doors were left on the side in the

lounge accessible to people using the service. Keys to a person's bedroom, the downstairs toilet (which contained a half full can of paint) and the electrical cupboard were kept in view on top of door frames, accessible to people using the service, staff and visitors.
• Chemicals or substances hazardous to health (COSHH), such as cleaning products were not stored safely or securely. We were concerned this increased the risk of harm to people due to potential misuse including ingestion. Water temperature checks were not completed to monitor and prevent the risk of legionella.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at increased risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reported these concerns to commissioners and sought urgent assurances from the provider to detail the actions they were taking to mitigate risks to people. Commissioners placed their own health and social care professionals at the service 24 hours a day to monitor people's safety and completed reviews of people's care with the provider. The provider implemented an action plan to mitigate risks to people.

Learning lessons when things go wrong

At our last inspection the service failed to implement systems to learn from incidents to make improvements and prevent reoccurrence. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was now in breach of regulation 17.

• Processes were not implemented to effectively review and respond to incidents and accidents to mitigate risk and make improvements to the service. Body charts were regularly completed to record unexplained injuries, but incident reports were not completed to account for the circumstances, antecedents or actions taken to investigate the potential cause. The registered manager told us, "If staff don't see someone get hurt, they don't consider it an incident."
• An incident report for one person reported they had accessed the kitchen unsupported during the night. It was unclear what the associated risks were as their risk assessment lacked information about this. The registered manager told us the person's bathroom door was kept locked as there was a risk of them drinking water from the tap. Speech and language guidance stated the person must not be left unsupervised with food. There was no record of the incident in the person's daily notes completed by staff. There was no exploration about how the person had gained entry to the kitchen, which should have been locked or why night staff had not intervened to provide support in a timely manner. There was no record of follow-up action to review risks.
• The service kept a summary log of some incidents for each person, however, the column dedicated to 'actions taken' was consistently left blank. There was no analysis of incidents and accidents by the service to identify themes or actions to improve policies, procedures or staff practice.

Systems were either not established or implemented to monitor events and learn lessons and continually improve the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to implement regular reviews of incidents to ensure risks were identified and responded to appropriately.

Systems and processes to safeguard people from the risk of abuse

• There was no system to log, monitor or investigate safeguarding concerns. The registered manager failed to report concerns to the local safeguarding authority as required which included unexplained injuries to people. We asked the registered manager why they had not reported in relation to one particular incident and they replied it was due to "circumstances" but declined to explain what they meant by this.

• A safeguarding referral was raised by hospital staff in relation to another person's dislocated shoulder. The registered manager told us the investigation had been closed by the local safeguarding authority and no further actions were required. We were concerned this was not factual as the local safeguarding authority confirmed they had informed the registered manager they were investigating the concern.

• We observed three different staff used physical interventions on one person on three different occasions, which all restricted the person's movement. These interventions were not identified or agreed as part of the person's care plan or risk assessment and we were concerned they were unnecessary and disproportionate. We saw and heard the person express emotional distress such as crying, screaming and self-injury in response to two of the physical interventions. Records between May 2021 and February 2022 showed the person had numerous unexplained bruises and marks on their body. The registered manager confirmed these had not been investigated by the service and said the person was known to engage in self-injurious behaviour. There was no evidence of action taken to protect the person from the risk of abuse in relation to unexplained injuries. The registered manager failed to recognise unexplained bruises needed to be reported to the safeguarding authority.

• Locking mechanisms on one person's bedroom door and another person's bathroom meant there was a risk people could be locked in. There was no mechanism, such as a thumb-turn lock, for people to let themselves out. People's risk assessments and care plans did not consider their needs and abilities to manage locks and keys safely. The registered manager told us they had not considered the type of lock mechanism to reduce the risk of deprivation of liberty. The nominated individual took action to replace these locks the following day.

• During our inspection a member of staff told us they had reported an allegation of abuse to the registered manager, "Sometime in December 2021." However, the staff member said they had not recorded the concerns on an incident report or anywhere else. They were unaware if the registered manager had reported the allegation. The local safeguarding authority confirmed they had not received a safeguarding referral from the service in relation to the allegation. We took action to report the allegation to the Police and the local safeguarding authority.

• 16 safeguarding referrals were raised by external health and social care professionals involved with the service in relation to incidents that occurred between 3 January 2022 and 16 March 2022. Prior to this, no safeguarding referrals had been identified or raised by the service. We were concerned this indicated the service was not able to effectively identify safeguarding concerns or intentionally failed to report as required. This increased the risk of harm to people from abuse.

Systems and processes were not established and operated effectively to prevent abuse of service users or investigate concerns. The service did not ensure that forms of restraint were necessary or proportionate to prevent risk of harm, or ensure that people were deprived of their liberty with lawful authority. This was a breach of regulation 13 (1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reported these concerns to commissioners and sought urgent assurances from the provider to detail the actions they were taking to mitigate risks to people. Commissioners placed their own health and social care professionals at the service 24 hours a day to monitor people's safety and completed reviews of people's care with the provider. The provider implemented an action plan to mitigate risks to people.

Staffing and recruitment

• The service did not ensure appropriate staff recruitment checks were obtained prior to employment. The service did not seek applicants' full employment history as required. One staff member had previously worked in social care, however, there was no evidence the service had sought employment references as required. One of their references had a handwritten note 'verified', without any details about how this was achieved.
• The provider's recruitment policy and procedure (undated) stated two employment references were required. It said where this was not possible then a total of three references including character references should be obtained. None of the four staff references were in line with this. For example, the two references for one staff member were from their previous colleagues and not their employer. There were no risk assessments or explanations about the registered manager's or nominated individual's decision to appoint staff without appropriate references.
• Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We found one member of staff's DBS was issued 17 days after their start date. There was no risk assessment or record of actions to mitigate risk pending the DBS being issued. There was no evidence the service had considered applying for overseas criminal checks where a candidate's application indicated they had only been resident in the UK since 2017. During our inspection we checked the same staff member's file for right to work evidence and could not locate this. After our visit the provider sent us a Home Office letter which stated it was not proof of their 'settled status', rather this could be viewed online. We were not assured the provider implemented robust systems to check the right to work.
• Agency staff profiles were not on file for two agency staff who were supporting people at the service during our inspection. We were concerned their suitability was not checked by the service prior to work.
• The provider's interview processes were not designed to demonstrate candidates' knowledge and skills to support people with a learning disability. There were no questions in relation to person centred care, people's rights or relevant legislation, communication methods or values. Answers to five questions were left blank for one staff member's interview and other questions answered with "Discussed" with no details about what was discussed. There was no scoring and minimal explanation about why the candidate who had no experience was suitable for the job.

Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role. This was a breach of regulation 19(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider created an action plan to review staff recruitment files to ensure appropriate checks were in place.

• Staff rotas were not updated to reflect who actually worked. Staff were not consistently allocated to provide people's one to one or two to one staff support. It was not possible to cross reference people's agreed support levels and hours to the staff rota. We were not assured rotas were effectively planned to support people to stay safe and meet their needs.
• A staff member told us, "Staffing levels are very poor as sometimes there are two permanent staffs and the rest are incompetent agency staff." January 2022 records showed between two and four agency staff were used to cover vacancies every day and between one and three agency staff every night.
• The rota and daily records showed male staff were deployed to provide one to one support for the entire shift to the three females using the service. One person's relative told us they had expressly informed the service only female staff were to provide support with personal care after they found a male staff member supporting them with personal care last year. However, we could not be assured this was being followed by the service.
• A safeguarding enquiry was underway in relation to a separate report that only one male staff member was

employed to work at the service on a night March 2022, which posed a risk to people's and staff safety.

We were not assured enough suitable staff were deployed to meet people's needs safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we recommended the provider consider current guidance on the safe recording of medicines and act to update their practice. Not enough improvement had been made at this inspection.

• Prescribed nutritional drinks and powders were stored in an area of the kitchen, where the temperature was not monitored. This meant that the nutritional feeds may not have the desired effect if they were not stored in the recommended room temperature.
• Most people had one or more medicines prescribed to be administered when required (PRN), however, we found not all PRN medicines had protocols in place to guide staff about how to safely administer PRN medicines. When PRN protocols were in place, we found that these were not always person specific. Therefore, we were not assured that staff would consistently assess people's need for 'when required' medicine administration. We found one person had been administered medicines to aid sleeping on a regular basis although it was prescribed as a variable dose 'when required'. Staff told us they intended to review this with the person's GP.
• Medicine care plans did not always have accurate and adequate information related to medicines. Care plans had information about medicines that people were no longer prescribed, including creams. This meant there was a risk staff member may not be able to support people's medical and health needs effectively.
• We found a dietitian's recommendation to provide a person with a homely remedy medicine was not implemented by the service. There was no recorded explanation about this.
• We found stock records for a person's PRN codeine was not accurate compared with physical stock held. There was no information about whether any action had been taken to investigate the discrepancy.
• Staff who managed and administered medicines, told us they received online medicine training. However, the provider could not demonstrate that all staff administering medicines were competency assessed to administer medicines safely to people.

Medicines were not always managed safely. This was a breach of regulation 12(1) This was a breach of regulation 12(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some people at the home were given medicines covertly. Covert administration is when medicines are administered in a disguised format. Medicines could be hidden in food, drink or given through a feeding tube without the knowledge or consent of the person receiving them. Information about how to administer medicines covertly were documented in people's care plans.
• Medicines in the medicines cabinet were stored safely and securely and temperature of this medicines storage was monitored and recorded daily.

Preventing and controlling infection
• We were not assured the provider was effectively managing risks in relation to COVID-19. During our visit staff failed to consistently check or record health screening for inspectors or a person's relative, such as COVID-19 test results prior to entry. This was also the case for a relative who was visiting the same day. The registered manager did not have a system to check whether staff were following government guidance in relation to COVID-19 testing.
• There was no reference to whether people were at increased risk of COVID-19 in their care plans or risk

assessments, or whether additional precautions were needed to protect clinically vulnerable people.
• We observed staff did not consistently wear face masks when supporting people in close proximity. We saw another staff member wore an apron and placed their coat on over the top when supporting a person in the garden on two different days. We saw another staff member put gloves on and then handled their car keys. We were concerned this practice increased the risk of cross contamination.
• The COVID-19 policy and procedure appeared to be missing key information. For example, the contents list referred to sections such as 'visitors', 'individualised care in the event of positive case' and 'admissions to care homes', however there was no content about these areas and we could not locate these elsewhere in the policies file. The provider sent us a risk assessment form entitled 'CORONAVIRUS(COVID-19)', dated 10 January 2022, which included measures to reduce risk, however we found these were not always implemented. For example, there were no staff risk assessments on file and no floor markings in place to support social distancing. The risk assessment stated hand soap, sanitiser and paper towels were available. However, we found the only staff toilet in use did not have any paper towels and there was no hand sanitiser offered or accessible to visitors upon arrival. A staff member added hand towels to the toilet in response, however, when we returned three days later we found no paper towels were in the staff toilet again.
• The service had not received a food standards inspection since opening. We contacted the environmental health local authority who informed us the service had not registered with them as required. The nominated individual told us they had registered the service via an online electronic form, which did not provide confirmation of this. The nominated individual felt the error was with the environmental health department and not the service.
• Food was not always stored hygienically. We found cold pizza in the oven and cooked/ prepared food in the fridge was not always appropriately labelled so people would know it was safe to eat. There were no food temperature records for a freezer containing food in the staff office.
• General waste bins outside were overflowing and black bags were split open and showed what appeared to look like a red bag used for soiled items, a plastic apron and wipes were on the ground. A full yellow clinical bag was placed next to instead of inside the yellow clinic waste bin outside. This posed an increased risk of cross contamination and infection.

The service had not established or implemented robust infection prevention and control procedures to effectively mitigate risk to people. This was a breach of regulation 12(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have also signposted the provider to resources to develop their approach.

• People had their own ensuite bathroom facilities which supported the isolation guidance in the event of a positive case.
• We found some records that showed staff received regular COVID-19 testing in accordance with guidance. The registered manager was able to talk through testing requirements knowledgably and showed us results sent to her phone from people's relatives prior to visiting.

Visiting in care homes
• We found people were enabled to visit in the community and at their family homes and their relatives were supported to visit them in the care home. Relatives informed us that staff had supported them to maintain contact with their family members during previous government restrictions.
• The visitors risk assessment had been updated January 2022, but referred to a different location and not Penley View. It stated, "No further visiting restrictions in place according to Government Guidance". There was no consideration about precautions taken to prevent infection during visits or in the event of a COVID-19 outbreak, in accordance with government guidance.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection we found systems in place to monitor staff training attendance and needs were no robust. This was a breach of regulation 17(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was now in breach of regulation 18.

• Staff did not always receive appropriate support or training to benefit people using the service. A staff member told us their training was frequently cancelled as they were required to cover staff vacancies on shift. The staff training matrix showed numerous staff training gaps such as moving and handling, infection control and food hygiene.
• A relative told us they felt staff needed training in autism to understand and meet their family member's needs. Records showed only two staff members out of ten (on the training matrix) had received autism training and there were no future dates planned.
• The provider sent us training confirmation for tube feed training (percutaneous endoscopic gastrostomy (PEG)) in January 2022. However, they did not know who had attended and there were no certificates or competency assessments on record. External health care professionals had raised two concerns in March 2022 about staff knowledge and skills of PEG. This was being investigated by the local safeguarding authority.
• The provider's policy and procedure for physical interventions referred to a particular training course and technique, which was not provided by the service. The nominated individual had no explanation for this.
• One member of staff who was authorised to administer medicines told us they could not recall having their competency assessed and we could not find a record of this on file.
• A night-time agency staff member told us they could administer medicines to people at night if needed, however there was no record of their medicines training or competency assessment. Agency staff did not receive training to meet people's needs such as learning disabilities awareness, autism, communication, behaviours that challenge, positive behaviour support or breakaway training. After our inspection the nominated individual told us that if medication was prescribed at night, then night-time staff would be appropriately trained and competency assessed. This approach did not account for prescribed 'when required' medicines, such as pain relief.
• An agency staff member told us they had received an induction about people's wellbeing and what they

needed to do at night. There were no induction records to evidence this. The same agency staff member told us they did not know if the person they were allocated to support could walk independently and did not know about their serious injury.
• No staff were being supported to gain national vocational qualifications.

The service did not always ensure enough suitably qualified, competent, skilled and experienced staff were deployed to support people. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded with an action plan to address the concerns raised, which included the arrangement of staff training to meet people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care plans and the support staff provided did not always reflect evidence-based best practice and guidance. For example, the service had not assessed a person's skin integrity where their needs indicated there was a risk of pressure ulcers. There was no guidance about how often the person needed to be repositioned to prevent pressure ulcers.
• There was no further information about how staff should support a person with their sexual health and relationships where this was an indicated need. The registered manager told us they had intended to arrange training for staff but had not had the time.
• There was no evidence the service had assessed people's compatibility with each other, or their sensory needs. The registered manager told us that people were not able to eat their meals together as they did not get on. One person expressed themselves through loud vocalizing. We observed this to be the case at night and we saw them shaking a metal filing cabinet located in the corridor close to their bedroom which made a loud noise. Staff told us this was usual for the person. The service had not considered the impact of noise on other people's sleep and wellbeing. The provider removed the filing cabinet and said they would review whether sound proofing would reduce noise levels.
• Two people's care plans did not include any information about why they received contraceptive medicine. There was no information about their support needs in relation to menstrual cycles. In response to our query the provider contacted the GP to arrange a review.
• People care records did not include oral health assessments; there was basic information in care plans stating the person needs full support to brush their teeth without any details about the type of brush or tooth paste or how often the person needed to attend dental appointment.

The service did not ensure that care plans fully identified or met people's needs. This was a breach of regulation 9(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Records showed people received input from a variety of health and social care specialists such as dietitians, occupational therapy and speech and language therapy in response to their specific needs.
• However, outcomes of health appointments were not always followed-up by staff. There was limited information about a person's six-monthly blood tests to check their thyroid and kidney function, or annual blood tests to monitor lithium levels. One health appointment record stated the person had a blood sample taken for lithium; however, this was undated and there was no record of the outcome of the blood test. Another appointment record stated a blood sample was taken but did not state what this was for and there was no record of the outcome.
• An occupational therapy report dated, 17 December 2021, advised the implementation of a falls chart and a national tool named 'Disability Distress Assessment Tool' to help staff understand if the person was in

pain. However, neither of these tools had been implemented by staff. The person's end of month support plan review, dated January (no year), described them as being in constant pain, sleeping most of the day and poor mobility. This document had not been signed by the manager to confirm their review and no actions were recorded in response to the report.
• One person's care co-ordination review stated that a podiatrist/chiropodist was needed, however, the registered manager told us this had not been arranged. They confirmed no one using the service had received external footcare since the beginning of the COVID-19 pandemic in March 2020. We asked why this had not been reviewed as restrictions were reduced over time, but they had no explanation for this. The registered manager said staff had been filing their nails instead but there was no record of this in people's daily notes.
• The same person's care records contained a letter from an Occupational Therapist following an assessment, which said regular eye examinations were required. There were no records of eye examinations in their care records and the registered manager did not know if an appointment had been made since the person had been admitted to the service.
• Another person's end of month support plan review described them as being in constant pain, sleeping most of the day and poor mobility. This document had not been signed by the manager to confirm their review and no actions were recorded in response to the report.
• The registered manager told us that no face to face or remote (due to COVID-19) annual health checks had been completed since before March 2020. We found a health appointment record for one person stated they had an annual review, however there were no details about what was reviewed or what the outcome was, other than "It went well and parties was happy or satisfied with the outcome".
• We found staff recorded some information about people's health in the staff communication book. This was signed by some permanent staff members to confirm they had read updates important for people's continuity of care, but not by agency staff. This meant agency staff may not be aware of people's current health needs.

The service did not consistently support people to access healthcare services and support to meet their needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to our inspection and their own monitoring checks of the service, the local commissioning authority and clinical commissioning group co-ordinated reviews of people care and health needs.

Supporting people to eat and drink enough to maintain a balanced diet
• People had individual menu plans and staff were able to tell us basic information about people's dietary needs. During the first day of our inspection we observed staff supporting people with their lunchtime meal and found staff did not follow people's menu plans. There was limited fresh fruit and vegetables available. We found a few bananas and apples, potatoes and onions in the kitchen. Frozen vegetables were available.
• One person declined the meal staff prepared, which was not in accordance with their menu. They were then told by staff they could have a jacket potato with tuna, which the person appeared to accept. A safeguarding concern had been raised by external health and social care professionals in February 2022 in relation to the same person not receiving a varied diet.
• One person required a specific diet and we found the service had some special food items in place to meet their needs. Staff did not follow the variety of meals on the person's menu plan. Staff told us the person had corned beef sandwiches everyday as this was what they liked. There was no evidence about how this was being monitored to review the person's nutritional wellbeing.
• One person's care record contained contradictory information about the food texture required to reduce the risk of choking. This meant staff did not have access to accurate information to meet the person's dietary needs. There was no reference to whether the person had been referred for a speech and language

therapy assessment for swallowing.
• Another person experienced frequent urinary tract infections. Their risk assessment did not identify or mitigate any associated risks with the person's hydration, such as fluid targets to monitor the person's fluid intake.
• We looked at national malnutrition screening records for three people. Staff failed to enter the information required on the form in order to assess whether people would benefit from a dietitian referral.

The service did not consistently identify or meet people's nutrition or hydration needs. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider developed an action plan to address the concerns raised.

Adapting service, design, decoration to meet people's needs
• The home environment was bare, paintwork appeared damaged and dirty in one person's bedroom and there was exposed plaster throughout areas of the home. The nominated individual explained some reactive adaptations had been made to a person's bathroom in response to their intolerance and damage of exposed fixtures and fittings.
• A sensory room was available on the first floor, which we saw one person accessed for short periods. This was not accessible to one person who was not able to use the stairs. There was no evidence of how the rest of the environment had been designed to meet people's specific sensory needs such as lighting, sound and touch.
• Maintenance issues presented a health and safety risk. For example, a curtain pole above the double doors to the garden in the lounge was hanging off the wall and a broken light fitting was left on top of a filing cabinet in the first-floor corridor. Window coverings were missing in two people's bedrooms and internal door to the lounge was propped open with a chair due to the door release mechanism not working.
• When we visited the service at night we found the home was not secure from intruders. There was a power cut in the area between approximately 5pm and 11pm, which meant the electrified lock for the front door was not working. We were able to access the building as the front door was open. Staff members on the ground floor told us they were not aware the front door was unlocked and did not ask how we had gained access. There was no consideration about how to secure the front door in a power cut. Two people on the first floor were known to wake-up during the night and access downstairs, which required them to walk past the front door. There was a risk people could leave the service unsupervised and come to harm. After our inspection the provider told us they felt the risk was minimised as staff were monitoring people's whereabouts.
• The door on the ground floor between the front door and corridor was dirty. There was debris such as bits of leaves and dirt on the stairs, which was in this condition throughout our onsite inspection.
• The service had a hoist which was kept in the staff office. The last service in June 2020 was out of date. Staff told us that no one currently used the hoist. After our inspection the nominated individual told us they would ensure the hoist was serviced in the event it was needed.

The service was not always clean, well maintained or secure. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). 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, 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.

• The provider told us they could not find any evidence of a deprivation of liberty application or authorisation for two people who were not at liberty to move around the home, or access the community unsupervised by staff. This meant the service deprived people's liberty unlawfully.
• The provider told us a third person's deprivation of liberty authorisation had expired November 2020. There was a delay of eleven months until the service took action to apply for a review.
• Mental capacity assessment records did not document how people and their representatives had been involved in decisions as required. One person's assessment recorded a decision to provide one to one support indoors and 2:1 outdoors dated January 2022. It did not clearly state why this support was needed. Another person's COVID-19 vaccination consent form was signed by the registered manager. There was no other information about whether the registered manager had lasting power of attorney or deputyship (legal authorisation granted by the courts) in order to provide this consent.

The service did not always implement the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to follow-up and apply for people's deprivation of liberty authorisations.

Inadequate

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 inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• We were concerned the service did not promote anti-discrimination values in relation to people with a learning disability, which is a protected characteristic in law. Staff did not receive equality and diversity training.
• A safeguarding concern had been raised by external health and social care professionals in February 2022 about staff using inappropriate, punitive terminology towards a person using the service. During our inspection we saw very little positive interaction or engagement from staff towards people. We observed staff provided basic instructions to people without warmth or reassurance, such as "Go back to your room" at night and "No, stop" when a person was crying, screaming and self-injuring.
• When we queried the impact of no window covering and day light on a person's quality of sleep, the registered manager told us the person was unaffected as they pulled the bed covers over their head. This showed a disregard for the person's wellbeing.
• When we visited the service at night, two night staff were heard to be laughing and talking loudly together. This showed a lack of respect and consideration for people who were resting and sleeping.
• One person had experienced a bereavement and it had been agreed at their care co-ordination review they would be given the opportunity to visit their family member's resting place. This had not taken place and there were no further records of the decision not to do so.
• Staff did not always take action to protect people's dignity. During our inspection, one person's bedroom and bathroom doors were left open whilst staff supported the person with personal care in the bathroom. Another person was in a state of undress and accessed the shared hallway. Staff made no attempt to support the person to dress or offer a form of covering to protect their dignity.
• A lack of window covering on two people's bedroom meant their privacy and dignity was not adequately protected. There was frosting partially covering one person's window, however, the person could still be seen from the car park in a state of undress. Another person's bedroom window was next to the front door and could be seen in their bed.
• We found people's care records were left on the side unattended in the communal lounge which were accessible to people using the service and visitors.
• The service used CCTV in the corridors, entrance and the sensory room. The manager and nominated individual (NI) could not provide a clear explanation about who was responsible for monitoring the CCTV and the frequency of this. NI gave an example that it was used recently to check how many night staff were on shift at Penley View. There was no impact assessment on people's privacy or information about how

people were consulted for the ongoing use of surveillance. The manager said the CCTV had been turned off for some time until recently but was not aware of the reason for this. After our inspection the provider advised us a CCTV spot check led the NI to query staffing levels on shift, rather than using it to check staff levels.
• Four people had commenced the service as teenagers and young adults. There was no evidence the service had supported people to access ongoing education and training. Care plans did not contain any information about people's goals or how to support people to maintain and develop independence skills.

The service did not always ensure people were treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reported our concerns to commissioners and sought urgent assurances from the provider to detail actions they were taking to address concerns and improve people's experiences.

• Some people's relatives we spoke with felt the service was caring with comments such as, "The staff are definitely caring as they are always smiley and relaxed. They buzz off energy" and "They do look after him and are very helpful. I can phone and they do talk well to the family – we can visit anytime."

Supporting people to express their views and be involved in making decisions about their care
• Throughout our inspection visit we saw no evidence of staff supporting people with their preferred methods of communication to enable their involvement and seek their views. Every time we saw one person they told us they wanted tuna. The staff member supporting them did not respond to this request or explore whether the person would like a snack or a different activity to engage with.
• We found mixed information about how the service involved relatives in decisions about people's care. Relatives told us they felt the service kept them updated about their family member and were involved in care reviews. However, we found relatives were not always informed about people's injuries, which meant they were not involved in decisions about how the service responded to these. Relatives also told us many staff members' first language was not English, which impacted upon their ability to communicate effectively with their family members.
• When we visited the service at 9:25pm we found all people using the service were in their bedrooms and in bed except for one person, who staff repeatedly told to go back into their bedroom. There was no evidence that people were supported to make choices about what time they went to bed.

The service failed to consistently involve people and their representatives in decisions about their care. This was a breach of regulation 9(1) of the health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

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.

At our last inspection we recommended the provider consider current guidance on administering medicines and act to update their practice. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• The service did not fully comply with the Accessible Information Standard to meet people's information and communication needs. Staff did not use communication tools in line with care plans to help people understand information or communicate their choices.
• The registered manager showed us some pictorial symbols and 'now and next' cards to help some people prepare for activities, which were in the manager's office. They said these had not yet been introduced due to not having enough time to show staff how to use these methods.
• Staff had not received communication training. Untrained staff were allocated to support a person who used Makaton (a form of sign language) to understand information and express themselves. We asked staff how they understood the person's choices. They said the person was able to point to objects of reference in front of them such as their iPad, television for the music channel or 'duplo lego'. The staff member said the person would hit their own chin to indicate they were unhappy about something; there was no other communication methods accessible to the person for them to express their emotions.
• One person's care plan stated staff needed to use a visual cue to aid communication but did not include specific information about what communication tools were to be used to support their understanding or communication needs. It stated staff were to use simple language and that the person used facial expressions and for staff to pay attention but did not expand on this. It stated the person may be sensitive to touch and all touch should be on her terms but did not expand on what this meant.

The service did not ensure people received personalised support to meet their communication needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• People were not fully supported to engage in meaningful activities. On the first day of our inspection we observed three people spent most of their day in the bedrooms. A fourth person spent time a lot of time walking around the corridors and into other people's bedrooms.
• One member of staff was sat next to a person in bed with a cardboard box of plastic balls. The staff member moved the balls around with her hands every now and then in silence. The person did not appear interested in this.
• Another person had Lego on the table in front of them and the music channel on for most of the day. During the fourth day of our visit we asked staff what activity options were available and they replied, Lego, TV and music. Every time we saw the person, they told us they wanted tuna. The staff member supporting them did not respond to this request or explore whether the person would like a snack or a different activity to engage with.
• A person's relative told us their family member was bored at the service and looked forward to going to the family home. Another relative said there was no structured timetable for their family member which they felt was needed. The person's care records stated the importance of having a structured visual programme of activities that should be used throughout the day, however, the registered manager said this was not followed by staff. The person's records also said they enjoyed swimming and should be enabled to take part in this activity, but this was not taking place.
• Staff told us it was usual for one person to be awake until at midnight and another person would usually wake up between 4-5am every day. There was no offer of activities during these times. People were expected to stay in their bedrooms until day staff arrived.
• Staff told us two people were supported most mornings to go to a park to walk and run about as they had a lot of energy. In the afternoon they kicked a football with staff in the garden or bounced on the sunken trampoline. A person's relative told us they had purchased the trampoline. Staff said two people particularly enjoyed this, however there had been no attempt to explore this type of activity in the community.
• A third person's care plan stated staff should use distractions such as football or painting. We were concerned the activities listed were in relation to the limited options available at the service, rather than based on the person's interests. A manager told us staff had helped the person to paint an empty plastic egg container a couple of weeks ago, but they had not shown any interest in doing any more painting.
• Some people had their own iPads which they used to access music and videos and to facetime their relatives. We saw the screen on two iPads were smashed and observed a staff member offered one to a person to use. We intervened and pointed out there was a risk the person could harm themselves on the broken screen, which staff had not considered.

The service did not provide people with personalised support to meet their holistic needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• We could not find a complaints/concerns file or system to log complaints at the service. The nominated individual said they did not know if the registered manager had complaints records; they were not aware of any complaints being made.
• The provider's complaints policy was not appropriate because it did not provide information about the local government ombudsman for social care or contact details if people were unsatisfied with the provider response.
• There was no information in people's care records about how they could raise a complaint if they needed to. People's end of month review template did not include a section about feedback from the person about their care. It was unclear how the service considered people's feedback, concerns or complaints.
• Relatives we spoke with did not make us aware of any complaints and told us they contacted the registered manager if they had a concern.

The service had not established a system to identify, receive, record, handle and respond to complaints. This was a breach of regulation 16 of the health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

End of life care and support

• The service was not currently supporting anyone at the end of their life. End of life training was identified on the training matrix, however, staff had not attended this and there was no information in people's care records about their end of life preferences.

We recommend the service seeks advice from a reputable source about end of life care planning.

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 requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found the provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. This was a breach of regulation 17(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider's governance systems failed to effectively monitor staff performance or the management of risk. The provider had taken previous action to appointment three managers for Penley View between July 2019 and February 2021. However, they had each left the service between four to six months after commencing employment. The nominated individual told us they were aware the registered manager had been difficult to work with, such as not always providing access to information and documentation. However, the NI confirmed the registered manager had not received any supervision, appraisal meetings or development plans since our last inspection to monitor or address performance issues. Another staff member told us managers of the service did not receive supervisions in their experience.
• In response to the challenges with the registered manager, the provider had appointed an operations manager to provide further oversight and support to the services. We were told by the provider not to communicate with the operations manager, who was suspended pending investigation due to anonymous information of concerns. The provider also took the decision to suspend the registered manager during our inspection due to their concerns with the registered manager's performance.
• Other staff had not received appraisals and supervisions were infrequent. We found the only supervision record for one member of staff flagged concerns about their capability, which included concerns about their ability to understand the English language. However, there was no development plan to support them to improve their skills to benefit the people being supported.
• Staff roles, responsibilities and accountability arrangements were unclear. The registered manager told us they had not had the time to give the only team leader in post, "The tools for the job". The deployment of staff meant basic tasks such as answering the door to visitors in a timely manner, or following visitor procedures were not managed effectively.
• The registered manager was responsible for managing two care homes. They told us when they were not at

Penley View another manager was responsible for the management oversight of the service. However, the manager told us they only checked with the team leader that they had enough staff on duty and no other input was expected or given. There was no written guidance about how this arrangement was expected to work; it was unclear who was responsible for people's welfare day to day.
• The nominated individual made us aware of ongoing changes to the management structure, which included the appointment of a new manager at the service commencing 21 March 2022. We were concerned effective management arrangements had not been established to improve service delivery nearly two years since we raised concerns about management oversight at our last inspection. The provider responded that it had been difficult to recruit a manager due to the pressures of COVID-19, which was why the registered manager had continued to be responsible for three services.
• The provider had not taken steps to recognise or address the increased inherent risks the service presented in relation to a closed culture. There was a lack of provider monitoring about how people, their representatives and staff were empowered to speak-up to ensure an open, inclusive culture at the service.
• Incident reports completed by staff were not evaluated by the service to assess or mitigate the risk of harm to people, staff and others. Risk assessments were not completed to consider whether the use of certified physical interventions would be appropriate to keep people and others safe in a crisis situation. A staff member told us another staff member had restrained a person who was physically aggressive towards them as they did not know what to do.
• Some records were difficult to access because the registered manager said they could not locate documents and there were delays in accessing information on their laptop due to IT issues. The nominated individual told us the registered manager had not followed correct records management procedures. We were concerned the provider's own monitoring systems had not addressed this.
• People's care records and managements records were not always secure, complete or up-to-date. For example, a person's care plan and risk assessment had not been updated to reflect changes in their health and their daily records did not document a visit to hospital. Other people's records did not contain complete information about their needs or who was involved in decisions about their care. The staff training record was not updated and lacked the names of five current staff members.
• During our inspection the nominated individual (NI) told us they could not maintain people's safety and decided to serve notice to all people using the service. This was later revoked when a new NI was appointed who felt improvements could be made.

Governance systems failed to assess, monitor and mitigate the risks to people or maintain securely accurate or up-to-date records of people's care or the management of the service. This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations.

The nominated individual (NI) decided to suspend the registered manager due to their concerns about poor management. The NI resigned from their post and a new NI was appointed 15 March 2022. We raised our concerns with commissioners and sought urgent assurances from the provider to detail the actions they were taking to mitigate risks to people.

• The service failed to comply with the requirement to notify the Care Quality Commission (CQC) of incidents that affected the health, safety and welfare of people using the service. For example, concerns that met the criteria for allegations of abuse and a serious injury were not reported. The service delayed reporting another person's serious injury to us.
• The service failed to notify CQC of previous deprivation of liberty authorisations for three people using the service.
• Since our inspection the service reported some new incidents to CQC, however, the information provided did not follow reporting guidance and failed to clarify how the service planned to mitigate ongoing risk to people. We were concerned leaders of the service did not fully understand or implement regulatory

requirements.

The service failed to notify CQC about incidents as required. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

• The service failed to provide CQC with an updated statement of purpose to reflect the correct provider address, or up-to-date information about the locations the registered manager was responsible in relation to regulated activities.

This was a breach of regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

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
• We were concerned there was a closed culture at the service. Incidents and accidents were not adequately monitored to identify potential notifiable safety incidents.
• The registered manager failed to carry out all steps in relation to notifiable safety incidents and did not act in an open and transparent way. They did not provide a written account or apology to people or their representatives in relation to two serious injuries.
• The registered manager failed to provide an accurate account to the Care Quality Commission in relation to the same two serious injuries.

The provider did not ensure the service acted in accordance with their duty of candour responsibilities. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• Systems were not established or robust enough to effectively monitor, evaluate and improve the safety or quality of the service. The nominated individual told us only one provider audit had been completed 20 January 2022 since our last inspection in March 2020.
• The recent audit identified gaps such as, 'Confusing paperwork with very little detailed R/A's [risk assessments] in general', 'No [staff] medication competency records', 'Very little up-to-date [staff] training on record', 'Bins full to overflowing with yellow and black bags' and 'Several Accident/Incidents documents do not show accurate timelines – no 'lessons learned' entries and no evidence of actions taken'. There was no time specific action plan in response to the areas of concern identified. Our inspection found the above areas for improvement had not been addressed by the service.
• There were no systems in place to monitor positive behaviour support plans to ensure these were appropriate and met people's needs or measure whether they were successful in minimising people's distress and potential risk of physical harm to themselves and others.
• No surveys or meetings were facilitated by the service to gather people's or their relatives/representatives' feedback about the service. The service had not considered how to adapt information to involve people and seek their direct input about service developments.
• Some people's relatives told us they had been informed about future management arrangements. One relative felt it was important the service had its own manager. Another relative told us the service, "Could be better with new ideas, daily planning and getting [the person] out into the community more". This was not identified in any service improvement plan or individual person's goal planning.
• We received mixed feedback from staff. For example, one member of staff told us the registered manager did not listen or take staff concerns seriously. Another staff member told us they were encouraged to raise any concerns and suggestions for improvements. Staff told us staff meetings used to happen. We were made aware of one recent staff meeting but there were no other staff meetings on record since our previous

inspection.
• We found five staff feedback forms, which were undated but the content about recent management indicated they were recent. Issues such as the lack of staff supervision and the need for more activities for people and personalised care were raised. There were no corresponding records to show how this information was evaluated or acted upon to improve the service.
• Records showed health and social care professionals were regularly involved in people's care, however, the service frequently failed to implement their guidance to achieve good outcomes for people. We received feedback from health and social care professionals the service did not always respond to their queries and requests for information in a timely manner.

Governance systems did not effectively monitor evaluate or improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The service failed to provide CQC with an updated statement of purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify CQC about incidents as required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not provide people with personalised support to meet their holistic needs.

The enforcement action we took:

We cancelled the manager's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not always ensure people were treated with dignity and respect.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always implement the Mental Capacity Act 2005.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users or investigate concerns.

The enforcement action we took:

Systems and processes were not established and operated effectively to prevent abuse of service users or investigate concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not consistently identify or meet people's nutrition or hydration needs.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The home was not always clean, secure or properly maintained.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service had not established a system to identify, receive, record, handle and respond to complaints.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems failed to assess, monitor and mitigate the risks to people and to monitor, evaluate or improve the service. The service did not maintain securely accurate or up-to-date records of people's care or the management of the service.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not ensure the service acted in accordance with their duty of candour responsibilities.

The enforcement action we took:

We cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not always ensure enough suitably qualified, competent, skilled and experienced staff were deployed to support people.

The enforcement action we took:

We cancelled the manager's registration.