The Otterhayes Trust

Otterhayes

Inspection report

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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
Otterhayes is a 'care home' providing personal care and accommodation for up to six people living with learning disabilities, Down's syndrome and/or autism. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection five people were living in the residential home known as Hayes House within a rural, private community with gates to prevent vehicles entering the grounds at speed.

Otterhayes also provides support under a supported living scheme for an additional 15 people with learning disabilities, Down's syndrome and/or autism living in their own homes as tenants. These were seven properties within the private community, all with links to the provider. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection the provider and registered managers did not understand what the regulated activity of personal care meant. We looked at the care provider to the 15 people living within the supported living scheme and found there were two people receiving personal care.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The providers and registered managers had managed the service for many years supporting people living with learning disabilities, Down's syndrome and/or autism. However, neither the providers or the registered managers had heard of Registering the Right Support at the time of our inspection. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

Following Registering the Right Support new services should not be developed as part of a campus style development such as Otterhayes as this does not follow best practice guidance. The negative impact on people was not mitigated by factors such as adequate staffing skills, effectiveness of management, and promotion of the principles of independence, choice and control.

People's experience of using this service and what we found
Otterhayes is owned and managed by The Otterhayes Trust, a registered charity. Members of the same family have roles within Otterhayes. This includes the Trust chair, registered managers and support workers who also live on site. People, families and staff felt unsupported and unable to make complaints and be assured these were managed independently of the family. Other family members also worked as maintenance and support workers. Although management had tried to support staff with personal issues, professional boundaries with staff were blurred because robust processes were not in place. This had led to

poor management of staff and low staff morale. Recruitment processes were not robust to ensure vulnerable people were safe and there was a lack of supervision and training to ensure people's needs were understood and met.

Although there were some care plans, these were not always up to date, and staff did not use them as working documents to inform care delivery. Risks were poorly managed, and accidents/incidents were not always understood or recorded as such which put people and staff at risk.

There was a lack of person-centred care. Staffing levels were not reflective of people's needs, there was no dependency tool to relate staffing levels to need. Staffing levels were set and not reviewed. People generally followed the service routines and staff did not know people's funded one to one staffing hours, ensure people were doing what they wanted to do or enable people to achieve any known goals.

Activities were mainly based on those available on site for additional payments, availability of staff and vehicles or accompanying staff with service tasks. The service location was rural and the nearby town was only accessible by car, which increased the risk of social isolation, independence and lack of consistent community links. Registering the Right Support states that services should be developed in locations that enable people to participate in their own local community.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; there was a lack of choice and control, limited independence and limited inclusion. People did not always have choice in the food they ate or at what times meals were served. Menus were developed by staff with little meaningful input from people who lived at the service. Other rules and restrictive practices were in place without following best interest decision making and there was a culture of management and staff knowing what was best for people.

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. (report published 12 June 2018).

At this inspection we found the service had deteriorated to inadequate in all domains and there were ten breaches of regulation.

Why we inspected
The inspection was prompted due to concerns received from various sources about areas of concern such as communication with people and families, access to finances, biased management of complaints, unsafe staffing levels, lack of person-centred activities, lack of best interest decision making processes, poorly managed safeguarding and overall poor management and support for staff.

Enforcement
We have identified ten breaches in relation to safeguarding, safe care and treatment, medicines, staffing and

recruitment, person centred care, consent, dignity and respect, complaints, governance and notifications during this inspection. We also asked the service to make a safeguarding alert in relation to an incident raised during the inspection relating to inappropriate comments made on social media by some staff, which they did.

CQC have taken enforcement action by imposing a condition on the provider's registration. This requires the provider to provide CQC with a monthly report outlining actions and progress in making the required improvements.

Special Measures
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 six 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.

Follow up
Following the inspection, we continue to meet with the provider and partner agencies to ensure immediate risks were and continue to be managed appropriately.

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 safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below.

Otterhayes

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection took place on 25 September, 2, 3 and 8 October 2019 and was unannounced on the first and fourth days. This inspection was carried out by two adult social care inspectors, an assistant inspector and an expert by experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second and third days by two adult social care inspectors and on the fourth day by a CQC pharmacist.

Service and service type
The Otterhayes Trust provides accommodation and personal care for a maximum of six people living with learning disabilities and/or autism in a property known as Hayes House. At the time of the inspection there were five people living in Hayes House. The service does not provide nursing care. All people who live at Otterhayes access healthcare through the local community health team. Hayes House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service also provides a domiciliary care agency service and provides personal care to a further 15 people living in seven supported living properties, with the aim that they can live as independently as possible. People's care and housing are provided under separate contractual agreements as tenants. However, the support and tenancies are not separated in this case. Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support. The service had two managers registered with the CQC. 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.

Notice of inspection
We did not give any notice of this inspection as we were responding to concerns received from seven separate sources.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We did not request that the provider completed a Provider Information Return (PIR) as this was an inspection in response to concerns. The PIR is a form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We were unable to speak with any visiting health professionals as people at Otterhayes did not currently require regular health visits. The registered managers said people accessed specialist health professionals when needed, however. We discussed the service with the local authority safeguarding team. This included the information of concern and information from whistle blowers. We reviewed the information that we had about the service including safeguarding records and statutory notifications. Notifications are information about specific important events the service is legally required to send to us. We also obtained the most recent care plan assessments from the local authority in relation to people living at Hayes House. We took all this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke and spent time with the five people at Hayes House. We also spent time with one person living within the supported living scheme who received personal care in their own home. Some people who lived at Hayes House were unable to verbally express their views to us, we therefore observed care practices in communal areas and saw lunch being served on three days. We spoke with five support workers, the Otterhayes Trust acting chair and an Otterhayes consultant and the two registered managers. We reviewed a range of records. This included five people's care records and seven staff members' records. We looked at records in relation to training and staff supervision, medicines and a variety of records relating to the management of the service, including policies and procedures. There were no audits other than the health and safety audit carried out by an external company monthly.

Following the inspection, we also spoke with two relatives who had concerns and received further concerns from two relatives whose loved ones received no personal care. We also received an email from a staff member. We shared these with the local authority safeguarding team with the relatives' consent.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as require improvement. This was related to areas of safety needing to be improved in managing behaviours which could be challenging for others, personal emergency evacuation procedures and environmental risks. At this inspection this key question has now deteriorated to inadequate.

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

Systems and processes to safeguard people from the risk of abuse

●People were not safe living at Hayes House. This was because staff were not up to date with their safeguarding training, did not follow local procedures when required and were not familiar with good safeguarding practice. For example, there had been one occasion recently when an incident involving a person living at the service should have been reported both to the local authority safeguarding team and the Care Quality Commission (CQC). When we discussed this with the management of the service, one of the providers said they had decided not to report the incident in order to not bring attention to the service. They said, "The person was having a funny five minutes". If incidents are not reported following safeguarding processes, we cannot be sure satisfactory preventative measures are put in place to ensure people are safe.

●Ex members of staff and relatives contacted CQC and the local authority safeguarding team to raise allegations that people living at Hayes House were at risk of unnecessary abuse or neglect. Following the inspection, both staff and relatives contacted CQC again to give more details about their concerns and the types of abuse they were alleging. This included physical, financial and institutional. For example, some families were concerned because they did not know what some financial withdrawals from peoples' accounts were for, and people were not having their care and support in line with their commissioned hours.

●CQC had received the last notification relating to abuse from the service in October 2018. However, support workers told us of examples of further incidents where we had not been notified. One support worker said a person with known behaviours, which could be challenging for others, had pushed another person living in Hayes House over. We shared this with the local authority.

● Staff were not all trained in the use of de-escalation techniques to support people in the management of behaviours which challenge and in the use of restraint. Only eight staff of at least 18 had completed training in managing challenging behaviours and breakaway training in October 2018. The registered managers had last had these types of training in 2013 and were therefore not up to date with training of this type and the suitable techniques to use.

●During our inspection, three support workers raised concerns about a fellow support worker. When we discussed this with the management team they told us they were aware of the concerns raised about this support worker who one of the providers said was "difficult to manage". They had not fully addressed the concerns. They had not fully addressed the concerns. The registered managers gave feedback to say the issues were complex and sensitive. However, this meant the staff member could carry on their possible poor practice.

●Information contained within the daily record/communications book confirmed physical incidents relating

to managing behaviours which could be challenging for others had occurred frequently. However, the information was not always transferred or recorded either in the accident records or people's ABC charts (a tool used to gather information on a certain problem behaviour).

●One concern from an ex support staff member alleged that when staff had completed incident reports, they were "changed due to the wording staff used which made me think they changed it in order not to report anything". Another ex-support worker told the safeguarding team, "We are never allowed to do incident reports ourselves, management do it. I strongly believe some incidents have not been reported at all." When we asked why staff were not allowed to complete forms, one of the registered managers said it was because staff spelling was wrong, and they had to rewrite them but staff could complete accident forms. We had not received notifications since October 2018 despite there being some incidents recorded in the ABC in 2019 for one person. One support worker told the safeguarding team they had seen another staff member 'frog march' people around and tackle a person to the bed in the past. The registered managers said they were not made aware of any such incident which they were surprised about.

People were not consistently being kept safe and protected from harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Risks were poorly managed, and people were not involved in managing their risks. Practice at the service meant people were at risk of unnecessary harm to themselves, staff and others.

●There was a lack of individualised risk assessments in place. One of the registered managers said peoples' risk assessments were based on a generic format which included risks such as kitchen, money, social clubs and anxieties.

●For example, one person who was assessed as a high risk of causing harm to themselves or others referred staff to "see guidelines on managing the behaviour" and "1:1 where possible." Staff were unaware of the guidelines when we asked about these. The registered managers said they were accessible in the separate office building. Information about how to manage this risk did not guide staff on how to manage the situation in a safe and consistent way by de-escalating the behaviour.

●Two people had a risk of eating food too fast which could lead to choking. This was identified in their old care plans. Staff did not use these care plans and information relating to this risk was not monitored or recorded in the daily records.

●People did not have updated risk assessments or management plans in place. Therefore, it was unclear if their initial risks remained. At our request, the service put care plans and further risk assessments in place that were more accessible to staff. We asked that an urgent staff meeting was held to ensure staff were aware of people's risks and needs. Where action was taken to assess risks, plans were unclear.

●At inspection, we identified one person who lived in the supported living units who suffered from epilepsy. They were known to have seizures and had a mattress alarm at night. However, there were no robust checks of the alarm as the 'sleep in' book did not always include confirmation the alarm was working. On one occasion the alarm was recorded as not working. The person was told by staff to ring for help if they needed it. They would clearly not have been able to do whilst having an epileptic seizure. If the alarm went off, the sleep-in staff member at Hayes House was alerted. As they could not leave Hayes House unmanned, they then had to call the on-call manager. Meanwhile the person would be having a seizure unsupported. We raised a safeguarding concern about this matter. Following the planned safeguarding meeting the day after the inspection this issue was included in the protection plan.

●There were no risk assessments relating to staff lone working on site or visitor books to know who was on site. This was despite some people displaying behaviours which could be challenging and with a history of aggression towards staff. This had not been identified by the service and put staff at risk.

Lack of assessing, monitoring and managing people's risks. 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

● Staff recruitment processes were not robust and put people at risk of being supported by staff who were not suitable to work with vulnerable people. The providers had no staff file for themselves containing any recruitment information. This was despite having one to one input with people and holding staff meetings and supervisions. One provider said they, "often had chats with people living at the service, for example such as following an incident, and this could be seen as a 'telling off'." They told us they did not keep records of these conversations. The second provider said, "I'd better get a DBS (Disclosure and Barring Service) then." The second provider had recently conducted staff supervisions and a staff meeting. The two registered managers' staff files contained no recruitment information, no identity check, no DBS, no references or application forms. Two family member's files, who were on the rota as working as support workers, contained only a DBS, despite being a relative saying these staff had been left alone with vulnerable people recently on holiday abroad.

●We checked staff files for staff who had been employed for long periods of time. These also contained no recruitment information, no record of DBS checks and no references. The DBS is a check to ensure potential staff are suitable to work with vulnerable people.

Poor recruitment processes did not ensure that people were safe from unsuitable staff.
This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Lack of adequate staff to meet peoples' needs placed people at risk. The rota showed staffing allocation based on locations and tasks rather than the needs of people. For example, records indicated there were routines that were based on staff availability rather than peoples' choices such as, 'once a week male staff can encourage male residents to have a proper shower and hair wash' and '[Hayes House] will have their afternoon cup of tea at 16.30 when new staff come on duty'. There was no dependency tool and the registered managers did not know people's needs in relation to staffing levels. For example, the providers, registered managers and staff in Hayes House, were unclear about who had personal care or how many one to one hours they needed or were funded for. All staff spoken to, told us they did not know what people's one to one hours were, and this was re-iterated in the concerns we had received prior to inspection. No contracts were held for people on residential placements. We could not establish how many one to one hours people were funded for and if they were receiving this care and the registered managers told us they did not know.

●There were set staffing levels of two support workers in Hayes House during the day and one sleep-in support worker during the night from 10.30pm until 7.30am. A registered manager told us they had to do the rota to keep the staff happy because staff did not like working for too long in Hayes House as it could be 'intense'. A support worker said, "It's hard work in here."

●The rota of the week ending 29 September 2019 showed that various staff were allocated at Hayes House. However, during each shift staff would need to take other people out or pick up and do other tasks such as leaving Hayes House to help 'garden' or prepare 'dinner' with other people receiving supported living support. This meant the rota was very complicated and different staff were often coming and going at Hayes House for short periods or to complete a task. This was not appropriate as some people living at Hayes House had high levels of anxiety. One person's funding care needs assessment said, "[Person's name] had autism and high levels of anxiety…. And does not cope well with change".

●Another person's plan dated 2016, said they were very particular as to which staff member helped them. There were no records as to who these staff were or whether this was considered in the rota.

●One person was supposed to receive 'emotional support' every morning for an hour. However, this was not on their care plan. When the sleep-in support worker was with this person, sleep-in records showed that another person had regularly asked for support during this time. The second person's needs were not met as the sleep-in support worker was working alone and could not address two peoples' needs at the same time. For example, in the sleep-in communications book, this person had knocked on the sleep-in door and asked for a book. They were told to go back upstairs or go back to bed.
●One staff member had made a written complaint to the registered managers which said, '[Support worker name] worked alone in Hayes House from 13.30 to 16.30 which is against our protocol as there should be two people working in there…. I feel it was totally unsafe for staff and residents." No action was taken to look at staffing levels and assess if they were adequate to meet peoples' needs.
●The sleep-in night support worker was responsible for responding to all 20 peoples' needs during the night. This included people receiving supported living. The sleep-in room in Hayes House was not close to all bedrooms so staff may not hear if anyone needed support. They would need to ring the on- call person if they needed help; usually one of the registered managers or their husbands responded (both couples lived within the gated community) who worked as maintenance and support workers.
●The sleep-in night support worker was unable to leave Hayes House so would need to manage support requests on the phone or call the on-call managers.
●Staff said at times there was only one support worker in Hayes House during the day. The registered managers confirmed that at times, since six staff had left recently, there had also not been any support workers to complete evening checks for people in supported living. They had not used agency staff to fill the gaps in the rota. When we asked why, the registered managers told us they had a bad experience with agency staff "a few years ago". We asked the service to urgently assess adequate staffing levels as part of the safeguarding protection plan following the inspection.
●Relatives reported concerns about staffing levels, and staff turnover. Six support staff had recently left in quick succession. One relative told us they were concerned there were some staff that had been "brilliant", but they had now left. Two other relatives had met with the provider about their concerns around staff leaving. They told the safeguarding team they were concerned about the loss of experienced staff and that there had not been many new staff to replace these. Staff said there used to be more staff and two staff working at night. One registered manager told us they were short of staff due to the number of staff who had recently left and were finding it difficult to recruit from the local area.

Lack of appropriate staffing levels to meet peoples' individual needs put staff and people at risk. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
● People's medicines were not always managed in a safe way. There were one or more gaps found in three people's medicines or creams administration records where a dose had been not been signed as given or applied when due. There were no recorded medicines audits to show that these gaps had been identified and investigated.
●When handwritten entries or amendments were made to people's medicines charts these were not signed or checked by another member of staff to make sure they were correct.
●When medicines were prescribed to be given 'when required' there was not always information available to guide staff on when or how these should be administered. Arrangements were in place so that any sedative medicines prescribed in this way could only be given by managers. However, we were shown a protocol for one 'when required' medicine where the reason for administration was incorrectly recorded on the sheet, and the dose recorded that could be given, was more than had been prescribed. We were told this sheet had not been available with this person's records but only held electronically by the managers who

would have been responsible for administrating any doses. There was no evidence the medicines had been administered incorrectly. However, this could have led to a risk of doses being given inappropriately. The managers told us they would be reviewing their arrangements for 'when required' medicines protocols and would be incorporating guidance from STOMP (a prescribing initiative which aim to stop the over-medication of people with a learning disability, autism or who display challenging behaviours).

●There were systems in place to report any medicines errors or incidents. However, one recent incident involving medicines taken out of the home for a person on social leave, had not resulted in new processes being put into place yet. The registered managers said they would ensure two staff signed medicines in and out relating to social leave. We were told there were spot checks and audits of medicines, but these had not been recorded. This meant that the service could not demonstrate that they would identify the shortfalls that we had found in the record keeping.

Lack of appropriate medicines management put people at risk. This was a breach of regulation 12 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

●Not all staff had completed infection control training, including the registered managers. The most recent infection control training was in 2016. We could not be sure that staff were following best practice guidelines.

●Although Hayes House was mostly clean and tidy inside at the time of the inspection, there was a household rota of chores which staff needed to do. Support workers were expected to carry out cleaning and cooking tasks as well as supporting people. The rota had many gaps that had not been signed as completed. One staff member said they had been at their "wits end" and had complained to the managers. Some staff said recycling was not always done properly, people's washing was not always done regularly or staff had not washed the bins leading to maggots being found. The registered managers said this was a one off incident buts staff task lists were not always completed or checked. Two staff members said some staff were not doing tasks, such as cleaning, and picking and choosing what they wanted to do or signing without doing the task. They said it was like "a hotel with no housekeeper to oversee". There were no records of any audits or spot checks to ensure tasks were completed. This meant cleanliness depended on which staff were on shift.

● Where able, people were encouraged to keep their rooms clean with support from staff. One relative said they had to help clean their family members room. The registered managers said they were unaware of this and they had a checklist which showed bedrooms were tidied once a week.

●The majority of staff had completed food hygiene training since 2017. The registered managers had not refreshed this training since 2003.

Lack of infection control training and management oversight did not ensure best practice was being followed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

●Although the service said they had good working relationships with local GPs we found health needs were not always identified and monitored appropriately. Staff said they were not able to write in care plans only in the daily records section. Therefore, there were notes about peoples' health that were not in any care plan and able to be seen by inappropriate people. For example, we could not monitor whether peoples' health was treated appropriately, such as a sore area between their legs or monitoring of a person's knee after a fall. There was no seizure record for a person living with epilepsy. The registered managers and staff at the time of the inspection were unable to say how often the person had had seizures. As part of the safeguarding protection plan, we asked that this was addressed. There were health folders for people more chronic conditions in the separate office building on site. Some people who had health conditions had information in these files which staff used to share information during a health appointment. For example, if a person had a long-term health condition. However, smaller short-term issues were just written in the daily records.

●There was no evidence of pro-active monitoring of peoples' medicines and side effects. One relative gave us an example of how they had had to contact the service repeatedly to ensure a person was on appropriate medicines and then book a medicine review. Medicines had been immediately changed. They had also had to arrange a private health appointment and take the person to a health professional themselves to get an issue addressed. Another note in the daily records said, "On new medicines. Staff to monitor". The support worker caring for this person said they did not know what this meant and they would have to read all the daily records to find out. Another relative told us during a telephone call following the inspection that a health issue had taken a long time for the service to address despite repeatedly asking and telling staff and the registered managers.

●One person in Hayes House had a health condition. Staff said they couldn't eat chocolate due to their health; staff could not tell us why or who had made that decision. Where one person was sick in the night, this was not mentioned again in daily records. Another person sustained an accident. The daily record said, 'cleaned and bandaged wound (no note of where the wound was) as would not stop bleeding, keep dry and check no more bleeding'. This was then only noted in daily records with no care plan despite staff using a topical cream and having to change bandages on the person's finger, thumb, feet, hands and foot. This was the same with another person with a rash noted at the chiropodists.

●One person was repeatedly noted to have topical cream on their 'really sore' feet due to a lack of insoles in their slippers. A note said, 'needs new slippers'. Seven days later it was still unclear how the person's feet were or if the slippers had been purchased. The person had been very tearful and emotional that week.

●One person's undated care plan said they had a history of picking their skin if anxious, which could become infected. There were no body maps for anyone, so we did not know what this person's skin condition was at present.
●Another person had back ache for a few days. They had not told staff but rung their family who had brought in painkillers. Staff were noting in daily records that the person had not complained about back ache, but a medicated spray had been given 'as requested by their mother'. There were no records about how to manage the person's pain or how they would tell staff. No GP appointment was booked.
●People's weights were monitored, and staff told us if they identified any concerns these would be referred to the GP. However, two people had put on weight meaning one person could no longer go horse riding. Their 2018 local authority care assessments said they would benefit from more physical activity to help maintain a healthy weight. We could not see evidence of how this had been implemented from the daily records on a regular basis as people did not have any recorded goals or care plans reviewed after 2016.

Staff did not always deliver safe, effective and consistent health 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
●Staff did not always have the skills, knowledge and competency required to do their jobs properly. This was because there was a lack of training undertaken. There was no overall training plan in place and the registered managers were not able to tell us how frequently they expected staff to complete training or what was considered mandatory. The registered managers asked us how they could access training in learning disability services.
●There were deficits in staff training which included areas such as health and safety, manual handling, first aid, basic food hygiene and fire training.
●Not all staff had completed recent specialised training, such as autism and epilepsy. This was despite being on-call for one person who had epileptic seizures. No staff had completed training in dysphagia (swallowing problems).
●There was no other specific training relating to people's individual needs, learning disabilities or medical conditions.
●The induction was not comprehensive and did not equip people for their job roles. Training consisted of a form ticking off tasks, house tour and fire exits. One staff member said, "The training used to be good … now we need a better training programme."
●Some staff had started the care certificate in 2016 but this had not been progressed or reviewed. New staff shadowed other staff but had no formal induction otherwise. Staff commented that, "New staff just follow us around and we verbally train them" and "There is not enough training." We could not be confident that new staff were learning the right way to support people. This was because as identified, existing staff had not had enough training or competency checks and development to meet the requirements of their role.
●Staff had not all received comprehensive induction training although they had been on the rota and recently been left alone supporting people. One person known to have behaviour which was challenging for others was noted in their daily notes to have 'joined [one of these support workers] at my house (on-site) for a hot chocolate and chat'.
●Staff did not receive regular supervision and annual performance-based appraisals. Their hands-on practical competencies were not checked. One support worker said, "I can't even tell you the last time we had supervision." There was no list of who had had supervision or not. When there were supervision records these were not using a standard format but focussed on negative issues or management fact finding. One of the providers had been asked by the registered managers to conduct a group 'supervision' as the staff would not listen to them. A staff member said, "I had supervision a few months ago … they [registered managers] have taken their eye off the ball and supervision has not been monitored. If regular supervisions took place,

it wouldn't be like this but they [registered managers] don't like conflict."

Staff training and supervision was lacking especially in learning disability issues and autism, which put people at risk. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- The delivery of care and support was not consistently in line with best practice guidance. For example, the provider was not following best practice guidelines in line with Registering the Right Support (RRS) and British Institute of Learning Disabilities (BILD). The management team were unaware of this information and had not seen the guidance. This meant the providers were not adhering to the principles and values of the guidance such as people's choices, independence and decisions.
- Prior to people coming to live at Hayes House, most people had received an assessment to ensure the service could meet their needs at the time. However, many of these assessments had not been reviewed and people's care plans not updated since 2013-16. Therefore, it was unclear whether the service could meet peoples' changed needs fully.
- One person's ABC chart showed they had shown aggressive behaviours relating to not wanting to eat with others or go to an activity. Actions taken had been reactive rather than pro-active and inclusive, asking people what they wanted to do following negative behaviours. Two months before an aggressive outburst, the ABC record had said the person would benefit from more 1:1 staffing but we could not see this had happened from their daily notes. The use of restrictive practices or rules were not being monitored closely as part of people's wider person-centred support planning and in line with recognised best practice.

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

- Although the service recognised the importance of people having a healthy and varied nutrition in relation to the maintenance of good health and wellbeing, people were not always able to choose what they wanted to eat and drink. When we asked staff about individual people's likes and dislikes, one staff member said there might be a list somewhere but "They all like everything".
- On all days of the inspection, people did not get a choice at lunchtime, everyone ate the same food, such as soup and cheese scones and squash to drink. One staff record stated, 'menus are not given much thought and are changed if staff do not want to do it, there is no thought of a balanced diet'. This was despite people being asked what they wanted from menu cards. People all had the same meal at the same time in Hayes House. Only if they indicated they did not want the meal, were they offered an alternative. Staff were told in writing in the communications book that 'only one person is to come downstairs for a drink in the morning as it is part of their one to one time'. If another person got up, they 'should be asked to go back to bed and informed that a drink will be taken up to them'.
- During the inspection it was one person's birthday. They were asked what cake they wanted, and they said chocolate. Staff made a lemon and coffee cake. A daily record stated that [person's name] wanted to buy a large bar of chocolate, but they were encouraged to buy a small bar and not to be allowed to buy a fizzy drink. There were no records about how restrictive decisions were made and the reasons why.
- There was a tuck shop on site once a week. Staff said people had little access to the shops unless the activity was on the rota or linked to picking people up from their jobs. Staff told us this was because staff were not all able or want to drive the vehicle and because there was not enough staff on duty. Staff said that people could not go out spontaneously very often. Some people were noted as particularly enjoying shopping in the care plans.

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

- People were able to personalise their bedrooms, but the communal areas of the home were very tidy and

sparse with no sense of peoples' input, interests or personality. This gave the appearance of a cold and unhomely atmosphere.
●Staff told us the house had few decorations, ornaments or pictures as one person would damage the items. However, this person had left the house last year and there were no risk assessments relating to restrictions relating to décor.
●During the inspection, the entrance area at Hayes House was being painted. Staff said that people had no input into the décor, colour or furnishings in the communal areas. A support worker said, "I wouldn't know if they [people] had chosen anything." There were no records about discussion of décor or what people would like to see in their home.

The care provided was not always tailored to people's individual needs and preferences.
This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Act 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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●Only six staff had completed MCA training in October 2017. Six staff had not completed the training, with the registered managers last completing this training in 2012. Six staff had completed Equality and Diversity training in October 2017. A further nine staff files showed they had not completed this at all. From reviewing people's care records and records of incidents, staff were not routinely implementing training into their practice. Where applicable, people's care records did not consistently contain capacity assessments.
●Consent to care, treatment and best interest decisions (BID) had not been obtained in line with legislation and guidance. There were many examples of staff making decisions for people who were unable to make choices for themselves. The guidance within the Mental Capacity Act 2005 had not been followed and BID had not been made by involving the relevant parties, such as health professionals and families. For example, what activities people wanted to continue to do and pay for, when to have meals, what to eat and drink and when, holiday plans and payments. All people had been asked to buy a flask for them to take to activities. There were no records showing the decision-making process.
●People were restricted in their liberty by locked entrance gates. People had to be allowed access to the premises and grounds. The service had five DoLS applications to the local authority which had been authorised. These only stated that people could not leave the service unsupported. This was contradictory to people's care plans which stated everyone living at Hayes House had not required a mental capacity assessment completing as they were able to make some simple choices and decisions; but needed support and guidance in some areas.People had last been shown how to access and open the gate in 2014 according to the registered managers. They said they would remind people how to access the gates.

Staff did not consistently work within the principles of the Mental Capacity Act (2005).
This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

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

● Relatives of people who lived at the service told us and the safeguarding team they did not all feel listened to and did not feel comfortable approaching management. They felt they were not informed about their loved one's lives and how they were getting on. One relative said if they made a negative comment they were not spoken to by management and 'blanked' which they said had made supporting the person receiving support from the service difficult.

● Staff and their relatives told us of their frustration with the management of the service and raised concerns around poor communication. Staff said they often had to write in the communication book repeatedly until things got done. Relatives told us they did not always feel comfortable discussing anything with the provider or registered managers, partly because they were all family. There were no arrangements in place for access to independent advocacy services for people, staff or family.

●Relatives said they had not been involved in discussions about peoples' holidays; where they wanted to go or with whom. They said they had not been informed of how a recent holiday had been as there was no holiday diary information or photographs to refer to. Another relative had said their loved one had said they did not do much and they had not known that only family members of the provider and registered managers' had gone on holiday. This included two support workers with no training or recruitment file.

●There was no evidence of any regular updates or overview of what people were doing, despite relatives asking or suggesting activities. Responses to relatives from management were that things could not happen due to low staffing or lack of funding. This was partly because people did not have recorded goals, person centred activities, opportunities to try new things and limited access to the community.

●People were not always able to verbalise their experience at the service but there were no records showing regular 1:1 reviews with people so staff knew they were happy with their support. However, people were able to communicate their satisfaction in other ways. For example, during our inspection, one person made rude gestures behind one of the registered managers' backs and another person gave us the thumbs down about two named staff to two inspectors. The registered managers said this could have been misinterpreted, however there were no communication records to inform others about how people communicated. One person's ABC chart had many references to the person not wanting support from a particular staff member or not wanting to do an activity offered such as cooking, drama or food shopping. This seemed to be when staff were paying attention to others. The person was funded for constant supervision due to behaviours which could be challenging for others. Any 'chats' with the person were not recorded. An action to increase 1:1 time was recorded but this was at a designated time in the early morning with whichever sleep in

support worker was on shift and content not recorded.
●There were no inventories of peoples' property including furniture to ensure it was clear who owned what and where they had bought it from and at a good price. One relative was concerned about a person's electronic device not being the one they had purchased. This was unable to be clarified by the service. There was no food labelled as for particular people if they had bought something they liked with their money.
●Staff and relatives did not know what finances people had available. One family had spent a lot of money buying regular items which could have been bought by the person. They told us they were worried about the future and who would make sure their loved one had what they needed.
●Team meeting minutes said, 'at weekends two or three people (unnamed people) from Hayes House can go out with one support worker'. This did not account for what individuals may want to do and depended on access to staff and vehicles.

Supporting people to express their views and be involved in making decisions about their care
●There was a lack of involvement with people which enabled them to discuss what support they wanted or what activities they wanted to do. Activities were not reviewed to ensure people were happy to attend despite having to continue to pay if they did not go.
●Many decisions were made for people without their recorded involvement. For example, a team meeting stated staff should avoid shops with one person, so they would be discouraged from buying certain items. Staff were told to go somewhere flat as people 'would happily walk without going into shops. This person's local authority care plan 2018 said they particularly liked shopping.
●Outings revolved around the staffing rota and routines, meaning people had to be back at Otterhayes for lunch or staff changeover. There were few spontaneous outings. For example, one person had said they would like to go to see a film at the cinema. They were told it would be sorted out, but it did not happen. The registered managers said, "We always arrange trips to the cinema when asked and staff often stay beyond their shifts to accommodate this and other outings."
●Most people at Hayes House were unable to have access to their monies, especially over the weekend unless staff had pre-ordered some money. Finances were kept in another office building and not accessible to support staff. Staff told us this meant they had to do activities which entailed no money. One concern received by safeguarding said that sometimes people could not buy an ice cream if they wanted one at the weekend. Staff and relatives said they did not know how much money people had or what they could use within their budget. There was no evidence of finance training to promote independence for people despite some people being able to recognise pictures of money in the past.

Respecting and promoting people's privacy, dignity and independence
●People's toiletries and personal items were kept in locked cupboards under the sinks in their bedrooms. Therefore, they were unable to get supplies of shampoo, soap or deodorant without asking a member of staff to open it for them. When we asked why these personal items were locked away, we were told by the registered manager that "some people might make a mess with them". This was not individualised. There were also signs displayed in people's private bathrooms telling them not to put their bathmats on the radiators to dry.
●The kitchen door had a keypad lock attached to it. We saw this being used to keep people out of the kitchen area. The staff member explained it was to "stop them winding each other up and getting in the way." When we asked why this area was locked, the staff member said they had one person who liked to go into the kitchen. However, this person no longer lived at the home.
●Due to the lack of organised staff support relating to peoples' needs, people did not always receive the support they needed. One person living in the supported living setting was 'found soiled in their shower at 10pm', they were known to need support with behavioural soiling. It was not clear how their support was funded or when or what they should do if they were soiled from their records. Daily records in Hayes House

with one sleep in support worker, showed people being told to go back to bed or go back upstairs when they indicated they needed support. These people had high levels of anxiety. Often this was because another person was receiving 1:1 care and there was only one staff member on shift.

●The ratio of male and female staff on shift had not been fully considered, especially as there was only one support worker asleep at night. There were no records of whether people were happy for male and female staff to support them. For example, two people needed staff to support them to access feminine products. One support worker said, "[Person's name] is better with males". ABC (behaviour charts) showed this person often shouted and swore at female staff.

●Because staff did not refer to care plans, which were out of date (2013-16) and kept in another building, people could not be sure their routines were known and adhered to. One support worker said, "It's in my head." This meant records showed people being woken early or at 2pm after having a nap and showing that they did not want to be woken. There was not a culture of person-centred language with staff saying, "I 'let' the person have their light on at night", "The dress [person's name] bought is to be kept for best" and "[Person's name] watching DVD at 10pm, I suggested they turn it off." One person had a star chart for 'good behaviour' but the support worker did not know how this worked or when the person received a star. There were no decision-making records around this.

●Peoples' needs were not always identified and addressed. For example, one person's local authority care plan 2018 said they showed they were anxious by asking a lot of questions. During the inspection, one person did this constantly and wandered around asking questions. Staff did not engage with them or ask them what they wanted to do. One support worker said, "They are always happy, they will tag along with anyone" rather than do something that was their own interest. People were generally fitting into staff tasks. Daily records showed people being told to wait with staff and watch whilst they ironed their clothes for example, so staff knew where they were. A support worker said there were no individual weekly planners for people, "They are all bored. People abide by the rules."

●There were no records or discussions for people about sexual health or relationships either despite people all being under 50 or socialising with other people.

Failure to ensure peoples' needs were met and they 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.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs. Some regulations were not met.

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

●Care plans were kept in a separate office building. Staff told us the care plans were not used as working documents. They were undated or dated 2013-16 and not up to date. A person admitted six weeks ago also did not have an Otterhayes care plan. The registered managers said staff could access peoples' full care plan on the new electronic care planning system. However, when we tried to view this with staff it was impossible to read as such small text and could not be zoomed in on. One support worker said, "Care plans are not my remit. Staff are on the ground running." The registered managers said they and team leaders wrote in care plans. There was a failure of ensuring people received consistent, person centred care.

●There were no records within peoples' house to show how they communicated despite many people having limited verbal skills. Care plans dated 2013-16 had communication information. Staff said one person used simple sign language. One support worker said they could use this, but staff could not find the copy of basic sign language as noted in the care plan. There was no easy read or pictorial information for people. For example, about the service, health education or what was happening in the community. Following the inspection, the service placed service user guides in peoples' homes which had some information in. However, there was no evidence this information had been talked through with people. One care plan dated 2013 said photo instructions may be helpful relating to personal care routines but staff were not using any. In an April 2019 team meeting staff raised that some people were not paying much attention to their personal hygiene. Step by step pictures for people were suggested but we did not see any staff using these and a staff member said there weren't any.

●Peoples' support information was kept in a range of documents rather than in a person's care plan. For example, in a sleep-in book, a location communication book, a general communication book and in team meetings. This meant staff could not be consistent in delivering care and management could not ensure peoples' full needs were known. For example, one person had been given the wrong medication to take with them on a visit to family but there was no evidence that this had been followed up with the pharmacy as noted in a communication book. One person had a routine to follow for personal care following a meeting in August 2018. This was not included in any care planning or accessible to staff in Hayes House.

●Some people living with autism were noted in their out-dated care plans that they liked their rooms kept as they liked it but there were no instructions about what this meant for people, so staff could be consistent. For example, one relative said a person kept everything very ordered at their family home and they were very sensitive. In Hayes House their wardrobe was not tidy as they liked it. In the past this had resulted in negative behaviours according to their relatives.

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

●Peoples' preferences, hobbies and interests were not considered. The service was run as a whole entity with people fitting into what staffing levels could provide and house routines. For example, activities were mainly morning or afternoon. One support worker said, "That's when we like to do activities". There were no recent evening activities or outings for people in Hayes House. Staff said people did not go out in the evenings. One support worker said, "Peoples' interests are set, that's what they do". Relatives told us they had been concerned for some time, repeatedly talking to management, about the lack of individualised activities for people. Management had not taken this on board or attempted to address the issue despite team meeting minutes stating, "Remember care residents if having a lunchtime nap need to be woken ready for 14.00 we need to remind you of the importance of keeping the residents occupied during the day, we have had family member who express their concerns that they are not occupied throughout the day. This can lead to behaviours which we don't want".

●Relatives said they were told increased activities were not possible due to staffing levels and funding. One relative said when asking if a person could visit other girls in the gated community was told, 'residential and supported living people can't mix due to their funding'. The person spent all their time with the same people which meant a lack of female company other than staff.

●Whilst special events were celebrated, other activities were mainly regular places everyone at Hayes House went from time to time such as the local donkey sanctuary, accompanying staff on pick up trips and a farm shop. Outings were based on the availability of staff and vehicles. Each person at Hayes House, for example, went on the same outings at different times. Most people had to go out with others and there were no up to date records about what individual people would like to do or who with. Local authority care plans dated 2018 highlighted activities individuals were interested in such as swimming, long walks, cycling, shopping or going to the pub and shows. None of these were recorded in up to date care plans or happening. For example, one person needed support to go swimming and their relative said they were really good at it. There had been one failed attempt some time ago. The registered manager did not understand that the person could be motivated with pictures, watching swimming and choosing a costume for example in advance to reduce anxieties. The activity had not been tried again.

●People appeared to be bored when the staff rota had not stated an activity. The activity board only had meals and recycling on it on the first day of our inspection. Whilst kitchen 1:1 was happening for one person in Hayes House another person was able to tell us they were bored. The other support worker was doing household chores. Staff told us some people regularly went for a nap in the afternoon. These were young people in their 40's. One of them told us, "Boring".

●During our inspection two people spent two afternoons sitting in the conservatory with little interaction from staff. One support worker said, "They often just do that." Team meeting minutes stated, "What we don't want to see is them both sat". Relatives told us they were concerned about one of these people's weight gain as discussed in the local authority care assessment in 2018. When at home the person loved to walk for miles. There was no evidence of long walks happening. They said they had raised this with management many times and now the person had put on weight.

●There was little evidence of people regularly accessing the community and people spent the majority of their time with peers or others with learning disability needs within the gated community. Staff said there was no community interaction, other than some people going to regular clubs. They said no-one had visits from friends from outside the home. However, people were supported to visit their families at home.

End of life care and support

●There were no records about peoples' end of life preferences, spiritual or religious needs. This meant that if there was a sudden decline in somebody's health, the service would not be aware of their last wishes to be able to carry these out.

The failures to ensure people received person centred care and support was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff and relatives consistently told us that if they had any concerns or needed to raise a complaint either with the registered managers or the provider, they would not feel comfortable to do so due to the number of management and support roles held by family members. There were no arrangements for any independent advocates for people or staff to contact. Staff and whistle-blowers said they did not know where to turn. This was especially difficult if there were issues with family members.
●There were concerns noted in local care assessments 2018 that stated parents were concerned about the amount of one to one time their loved ones were receiving but this had not been addressed. The documents said that 'Otterhayes would be addressing these and ensuring people were supported to access one to one activities.' Relatives said they had raised the lack of activities many times as well as concerns about finances. These concerns were not recorded as complaints. The registered managers told us they 'probably' didn't record all complaints.
●Following the inspection, one relative told us, "Often when we write or phone with a concern it is followed up with a request to meet rather than receiving a letter or email explaining our issue. Despite numerous requests and emails asking for some kind of future plan for [person's name]'s development we never had a satisfactory outcome."
●A relatives' satisfaction survey from 2018 had no action plan showing issues had been dealt with. A relative following the inspection told us they had had no communication following any questionnaires.
●Staff comments in two complaint records stated, "All I asked for was support from my manager when we were already working with short staffing, you [the managers] were on call and weren't prepared to help. A staff member sent a further email after making a written complaint. They stated that the complaint had not been responded to, that they had experienced being 'ignored' by members of staff and that they 'feel I'm being bullied by senior management'."

People, staff and relatives had no access to independent advocates and could not be sure investigations were unbiased. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

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

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

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

- There were widespread and systemic failings identified during the inspection; there were ten breaches of regulations. The shortfalls related to all the key aspects of the management of the service and included: safeguarding; safe care and treatment; person centred care; privacy and dignity; staffing; staff recruitment; complaints; statutory notifications, and good governance.
- The management did not understand the principles of good quality assurance as a tool to drive improvement. The provider's quality assurance systems and processes did not ensure risks to people's health, safety and welfare were identified and mitigated.
- The lack of quality monitoring of the service had led to significant deficits. This meant insufficient resources were directed into the areas that required improvement within a reasonable timescale, particularly in relation to staffing and safeguarding concerns.
- Poor leadership and management at the service were identified from the provider and joint registered managers down. They were out of touch with what was happening at the service and were removed from dealing with urgent issues due to a fear of conflict management. The registered managers were aware and recognised the deterioration of the service. They said they believed this had started in 2017. One staff member said, "At first it was OK, now I can't do this anymore … the management are detached from the real world."
- Staff spoke of confrontation and conflict between ex members of staff and the registered managers. They described some staff as having their own agendas and described their poor work ethic. They said they worked against the registered managers. One staff member said, "They wanted to make trouble before they left … they were all as bad as each other … they had a battle with the girls [registered managers] and had it in for them." The staff member described the registered managers as "lovely people but too emotional."
- The registered managers had failed to undertake their role effectively and were removed from the day to day running of the service. They were not visible at the service and were not regularly seen. One staff member said, "They [registered managers] are in the office all the time, I can go a week without seeing them … I actually had a chat with [registered manager's name] the other day, it rarely happens but it made me feel better." Another staff member said, "We just don't see them and the other day they passed me and didn't even speak."
- The leadership of the service was weak and inconsistent. The management structure of the service was also unclear and confusing. Whilst there were two full-time registered managers in post, they were both

unaware of each other's role and had no clear definition of responsibilities. There was also another member of the family who was a 'Consultant' to the registered managers, but their role in the management of the service was unclear. The consultant had different ideas of how to manage the service which meant more confusion for the staff who worked at the service with conflicting guidance. For example, one staff member said, "The girls tell us one thing and then we are being told another thing." The registered managers said they had brought them in because, "Staff wouldn't tell us anything."

●The service had Charity status and as such there was a board of trustees which had responsibility for the overarching responsibility on how the service was run. However, problems had not been addressed by the trustees either and this was not helped as a family member was the chairperson of the trustees. This meant a conflict of interest. There had been some turnover in the trustees and one previous trustee told us they had left due to how the service was being run. They said, "The Trust lack any form of financial and procedural governance structures" and there was a "reluctance for outsiders to look at their accounts."

●There was an absence of a robust governance system to ensure records were analysed and completed accurately by staff. This meant staff exposed people to risks of unsafe or inappropriate care or treatment. For example, there was no system to monitor the records relating to the running of the service and ensure the service held current and accurate records about people's care, finances, medicines, accidents, incidents, safeguarding, staff recruitment and audits. One relative said due to unaddressed maintenance issues their loved one had displayed destructive behaviour to try and solve the issue themselves.

●Records did not always contain the information required to protect people from the risk of unsafe care. There was also a failure to identify recording errors and omissions in people's care records to analyse to look for trends or patterns, such as behavioural charts or incidents

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●Peoples' overall engagement with the local community was minimal. As a result, peoples' links were no longer forged by staff, so people were restricted to mainly staying at the service or outings to set places. Due to the rural setting on a country road, people could not access the nearby town without staff support. One staff member said, "All the people have bus passes and staff have companion bus passes, they are never used, it's laughable." Where staff had supported people in the past with a failed community activity, staff had abandoned this activity without looking at the reasons for its failure and working out a plan to manage it. For example, a person had gone swimming once. This was noted in their local authority assessment as a 'goal', but no further attempt had been made. Another person was known to really enjoy recycling and had previously visited the recycling plant. They no longer wore their special high vis jacket and only went on random trips to the tip if staff knew to ask them. A staff member said, "When I look back we used to do lots but now they are disengaged from the community" and "[person's name] just doesn't want to engage now and just wants to come home."

●The service had a culture which was closed and not inclusive with a segregation between management and staff. There had been a high staff turnover within the last few months with several long-standing members of staff having left. As a result, the service was short staffed and morale in the staff team was very low. The registered managers were aware of the shortfall in staffing levels but had not approached recruitment agencies for help to fill the gaps in the staff rota. A staff member said, "We can't take people out because we are short-staffed".

●Staff did not feel listened to, respected or supported. They said they had told the registered managers about the lack of staff. One staff member said, "Sometimes it's (work) just horrendous and it's so hard here." Another staff member said, "I was at my wits end. Staff just pick and choose what they want to do. [A registered manager] changed the household chore rota but it doesn't help." The registered managers told us they had set up the staff rota to please staff who had told them it was too hard in Hayes House for a

whole day. This had resulted in staff working for a few hours in Hayes then then going out, then working in the supported living scheme and had no bearing on people's needs or consistency of staff.

●Staff did not feel able to be open with the management when things went wrong for fear of reprisal or discrimination. Whistle blowers were not supported and felt unable to raise concerns with the management. Therefore, concerns had been sent directly to the Commission and the local authority. The registered managers said they felt there was a staff vendetta against them and the providers said they felt staff had let them down.

●Relatives also shared a fear of raising concerns in case it had a negative impact on their family member. This made relatives and staff feel uncomfortable about reporting any concerns for fear of reprisal, discrimination or losing their jobs. Concerns had been raised between relatives when they met each other and they knew some had gone to the Commission. A staff member said, "I have no faith things will be dealt with."

●There was a website and Facebook page for the service, but these were not used and years out of date.

●Safeguarding concerns were not dealt with in an open and objective way. Management did not follow the necessary procedures and share this information with the relevant authorities. These incidents were kept 'in house' or not recognised as safeguarding, which was considered best practice and the Chairman of the trustees did not want to 'draw attention' to the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

●The provider did not ensure their responsibilities relating to the duty of candour was adhered to. This was due to the complaints, concerns and incidents reported which had not been either recorded, investigated or notified effectively by them.

Continuous learning and improving care; Working in partnership with others

●Communication about changes in the service was poor. Handover between shifts was ineffective and key information about people was missed. Important relevant and personal information was written in three different communication books as opposed to being recorded in people's individual care records. As a result, information could be missed as tasks were not ticked as being completed.

●The registered managers and providers themselves had not had any up to date training for some years. There was a failure to ensure effective supervision and training for the staff team overall had taken place as well as staffing meetings. This gave little opportunity to provide feedback to staff and share learning and good practice. However, team leaders were undergoing level 4 diploma courses.

●There was little collaboration with external shareholders and little evidence of partnership working

Failure to ensure good governance of the service people were placed at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. These notifications tell us about significant events that happen at the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to safeguarding events and serious injuries since October 2018.

Failing to notify the Commission about these changes meant we had been unable to monitor concerns and consider any follow up action that may have been required.
This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents
Personal care	Failing to notify the Commission about these changes meant we had been unable to monitor concerns and consider any follow up action that may have been required.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Personal care	The care provided was not always tailored to people's individual needs and preferences. Failure to ensure people received person centred care and support

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Personal care	Failure to ensure peoples' needs were met and they were treated with dignity and respect.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Personal care	Staff did not consistently work within the principles of the Mental Capacity Act (2005).

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Lack of assessing, monitoring and managing people's risks. Staff did not always deliver safe, effective and consistent health care. Lack of appropriate medicines management put people at risk.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not consistently being kept safe and protected from harm.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People, staff and relatives had no access to independent advocates and could not be sure investigations were unbiased.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure good governance of the service people were placed at risk of harm.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Poor recruitment processes did not ensure that people were safe from unsuitable staff.

Staff training and supervision was lacking especially in learning disability issues and autism, which put
people at risk.
Lack of infection control training and management oversight did not ensure best practice was being
followed.
Lack of appropriate staffing levels to meet peoples' individual needs put staff and people at risk.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration.