Metropolitan Housing Trust Limited

Langdon Park

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Langdon Park is a care home for up to 7 adults with learning disabilities and autistic people. At the time of the inspection 6 people were living at the service.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support: Staff did not focus on people's strengths and did not support people to have fulfilling and meaningful lives. People were not supported to pursue their interests, aspirations, or goals. People lived in an environment which was not clean or safe and did not always meet their needs. The environment was not interactive or stimulating. Medicines were not always managed in a safe way. People were not always able to make choices, and when they expressed choices, these were not always respected. People were able to access the healthcare services they needed and were supported to maintain good health. People were not physically restrained by staff.

Right Care: People did not always receive kind and compassionate care. The staff did not always respond to people's individual needs. People were not always supported to communicate with staff and not provided with enough information or staff who knew how to communicate with them. People did not always receive personalised care which met their needs. There were enough staff and they received training in a range of areas to help equip them with the skills and knowledge they may need. However, they did not always implement best practice from their learning.

Right culture: People were not empowered to make decisions and achieve their aspirations. They did not receive good quality care and support because staff did not understand, or did not want to, deliver a personalised service which reflected best practice for people with learning disabilities and autistic people. The staff turn over was low and staff told us they had good relationships with people. However, the support they provided focussed on basic tasks and not on promoting individuality and independence. There was a risk of a closed culture because staff did not always act in an open and transparent way and did not always accept the view of others, including people who used the service, which challenged the way they wanted to work.

For more information, please read the detailed findings section of this report. If you are reading this as a

separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 1 September 2018).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support, right care, right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, meeting nutritional and hydration needs, premises and equipment and good governance at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Langdon Park

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 conducted by 2 inspectors.

Service and service type
Langdon Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Langdon Park 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We looked at all the information we held about the provider, including notifications of significant events. 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.

During the inspection
We met all 6 people who lived at the service and staff on duty who included the registered manager. We spoke with people during our visit and on the telephone. In total we spoke with all 6 people, the registered manager, 4 support workers, 1 senior support worker, a volunteer, an interpreter who was supporting 1 person, the relatives of 3 people and 1 social care professional. We looked at records used by the provider to manage the service including audits, meeting minutes and selected care records including the care plans for 2 people. We also looked at how medicines were managed, and records associated with this.

We observed how people were being cared for and supported. Our observations included the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We inspected aspects of the environment including checks on health, safety and cleanliness.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- The systems for preventing and controlling infection were not being followed. There was unsafe food storage including unrefrigerated raw meat, dirty food storage, preparation and cooking areas and poorly stored, open packages which were not labelled.
- The environment was not sufficiently clean. The kitchen, communal lounges, bathrooms and the laundry room had areas which needed deep cleaning. Dirt, dust and/or grease had gathered on equipment, walls and flooring which presented a risk to people's health and wellbeing.
- The staff on duty did not know what the provider's procedures were about wearing masks as personal protective equipment (PPE). Staff did not always demonstrate an understanding about how to correctly wear masks.

Failure to follow safe practices for preventing and controlling infection was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed our findings with the registered manager. They explained more about the provider's procedures for wearing PPE. They told us they would take action to address the concerns we identified.

Using medicines safely

- Medicines were not always managed in a safe way.
- The staff did not always follow safe practices when administering medicines. We saw them leave medicines for one person on the table whilst they were eating their breakfast. The staff signed the administration chart to state the person had taken their medicines before this happened and left the room. This meant there was a risk the person would not take their medicines and staff would not be aware of this.
- Medicines records were not always clear or completed correctly. Staff had altered the medicines administration chart for one person by crossing out two of the medicines recorded by the pharmacy and handwriting a different medicine instead.
- There were no protocols or administration charts for some 'as required' medicines and some homely remedies (non-prescribed medicines). This meant there was no system for staff to judge when these medicines were required or for them to record administration of these.
- When staff had administered other 'as required' medicines, they had not always recorded the reasons for this, not recorded the information in the correct place and had not stated whether the desired effect had been achieved.
- Some people were prescribed medicated creams. There were no directions about when how or where these should be applied.

● The staff monitored some people's blood glucose levels as part of the management of their diabetes. The solution used to help with quality checks of the testing equipment had expired in March 2022. This meant there was a risk this was no longer effective at ensuring accurate readings.
● Medicines were not securely stored because staff left the keys to the medicine cabinet on top of this. Staff carried out checks of the temperature of medicines cabinets each day, but these checks did not account for peeks in temperature during the day because staff were not resetting the thermometers to check for maximum and minimum temperatures.

Failure to manage medicines in a safe way was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● The provider did not always assess or safely manage risks within the environment. Three fire doors were wedged open in a way which meant they could not shut automatically. This meant that in the event of a fire, smoke could spread more quickly through the building. We discussed this with staff on duty who demonstrated a lack of fire safety awareness in this respect.
● The staff had not cleaned the filters on tumble dryers. The build-up of dry debris was a fire risk.
● Cleaning products were not locked away safely and in accordance with the provider's procedures. We found a variety of different cleaning products, including bleach, in bathrooms, toilets, the kitchen and laundry room. This placed people at risk if they used these products inappropriately and did not understand the dangers associated with them.
● The provider had a number of first aid boxes throughout the home. We found items within some of these had passed their expiry date. This meant the first aid items were not suitable for use and may not have been effective. This also indicated staff members did not always check the first aid box contents for expiry dates.
● Some equipment was broken and posed a risk to people's safety. We found radiator covers were loose and could be accidentally removed if knocked, exposing sharp edges and hot surfaces.

Failure to assess and manage the risks within the environment was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff assessed the risks relating to people's personal care, health and wellbeing. These assessments were incorporated into care plans and regularly reviewed.
● People were not restrained and there were no imposed restrictions on their freedom to move around the house or to go out if they wanted.

Learning lessons when things go wrong
● The systems for learning when things went wrong were not always well implemented.
● Records of the last two fire drills included statements that indicated these had not gone as planned. Following a fire drill in June 2022 the record showed this had, ''not worked well.'' There were no recorded lessons learnt following this or retraining for staff. Records from the next fire drill in December 2022 sated that, ''when the alarm went off [people] did not bother to make any movement until told to by staff, so they need to try to get to understand what is happening.'' A further fire drill in December 2022 recorded that, ''None of the customers engaged with the evacuation.'' The provider did not follow this up with people until a meeting in February 2023. The next planned fire drill was not until June 2023.

Failure to effectively operate systems and processes to mitigate risks was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and staff discussed accidents, incidents, and safeguarding alerts. They investigated these and made plans to improve the service.

Systems and processes to safeguard people from the risk of abuse

● There were systems to help protect people from the risk of abuse. Staff undertook training on how to recognise and report abuse and they knew how to apply it. However, they had failed to recognise that some of their practices did not respect people's human rights.

● The staff worked with other agencies to report, invest and respond to allegations of abuse.

Staffing and recruitment

● There were enough staff to provide care and keep people safe. There were some staff vacancies, but the provider sourced familiar temporary staff and staff overtime to help make sure staffing levels were maintained.

● There were systems for recruiting staff. The registered manager and provider carried out a range of checks on staff as part of the recruitment process. New staff completed an induction into the service, which included shadowing experienced staff and tests of their skills, knowledge, and competencies.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The environment did not always meet people's needs through reasonable adjustments. One person living at the service was deaf. There were no visual alarms to alert them when the fire alarm was activated. Doors throughout the building were heavy and did not automatically open making it hard for people in wheelchairs, and with other mobility and dexterity needs to operate these independently. This restricted their access around the building and independence.
- The environment and equipment were not well-maintained. Areas of the building needed repair and redecoration, including marked walls and ceilings, damaged flooring and woodwork and broken fixtures on the washing machines.
- The interior and decoration were not suitable because they had not been adapted in line with good practice to meet people's sensory needs. There was limited signage. Where there were signs or information, such as notice boards, these were out of date, inappropriate or not completed. The environment was not appealing with pictures taken off the wall and left on the floor, a mixture of personal possessions, rubbish including used medicines pots and games stored inappropriately, a fish tank so dirty the glass was no longer see through and Christmas cards still on display (in March).

Failure to make reasonable adjustments to the environment, to keep this clean and in good state of repair and to ensure it was suitable to meet people's needs was a breach of Regulation 15 (premise and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a vibrating pillow which indicated when the fire alarm was activated for the deaf person when they were in bed.

- The registered manager told us they were consulting with specialist healthcare staff about how they could equip the building with automatic doors which would be easier for people to use.

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

- People were not always supported to have a choice of food. One person told us they were not given enough fresh food and most meals were made up of processed or frozen food. This was reflected in the food we found at the home and in records of meals people had eaten. One person did not eat meat, the menu plan showed only meals with a meat element and no alternative. Although staff told us this person was given alternatives, these had not been planned for in advance to help the person make choices about these.
- On the morning of our inspection one person told staff the specific meal they would like for lunch and that

they would like to help prepare this. This meal was not provided, nor was the planned menu followed. The person was not invited to help prepare any food. The 5 people who ate lunch were all given the same meal which was pre-plated by staff before they arrived in the dining area so they did not know what they would be given in advance and were not able to make choices.
● Food was inappropriately stored, and this presented a risk to their health. For example, packets of processed meat, fish and cheese had been opened and were not sealed. Food was not labelled with the date of opening. Some food had been decanted into containers, but these were not labelled with the contents or date. Some food was not stored at the correct temperatures, for example raw meat being stored in the oven. There were no records of stock rotation for frozen food to make sure older food was used first. The freezer needed defrosting. Inappropriate storage of food presented a risk this would not be safe to eat.

Failure to support people to make choices about their diet and to ensure food was nutritious and safe to eat was a breach of Regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were able to have snacks and drinks when they wanted. Except for 1 person, people told us they liked the food they were given. We saw people ate their breakfast and lunch and this was provided in sufficient quantities. People were offered hot and cold drinks throughout our visit.
● The staff had worked with other healthcare professionals to support one person to follow a weight loss programme. The external professional we spoke with told us this was an example of successful support and had resulted in the person achieving a healthier weight.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed before they moved to the service. They were able to visit the service and meet with staff and managers. They, and their representatives, were consulted about how they would like to be cared for.
● Assessments were used to help create care and support plans. These were regularly reviewed and updated when people's needs changed.
● Healthcare professionals were consulted and had an input into assessments and care plans.

Staff support: induction, training, skills and experience
● People were supported by staff who were trained and experienced. Many of the staff had worked at the service for a long time and knew people well. Staff received regular training updates in line with good practice guidance and legal requirements. However, staff did not always implement good practice.
● Staff were supported to undertake qualifications in care to help increase their knowledge and learning.
● New staff undertook inductions which included shadowing experienced staff and a range of training.
● There were regular staff meetings and opportunities for staff to meet with the registered manager to discuss their work.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with multidisciplinary healthcare professionals to assess, monitor, and meet people's healthcare needs. The staff liaised with these professionals and followed their guidance and recommendations.
● The staff had created health action plans which set out about people's healthcare needs and how they should be supported.
● People had the opportunity to meet with key staff to discuss their health and to plan for any appointments or changes to their support plans.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

- The provider was acting within the principles of the MCA. People living at the service had the mental capacity to make decisions about their lives and consent to their care and treatment.
- The provider worked with people's family, commissioners, and legal representatives to help make decisions in their best interests for more complex decisions.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not always well treated or supported. On two occasions we witnessed members of staff telling people to go into another room and sit down when the person started to speak with them. We heard staff talking about people in front of them and others, sometimes in a demeaning way.
- People's choices were not always respected. For example, 1 person asked for a drink of water. Two members of staff discussed this with each other and decided to give the person a different drink instead of water, without consulting the person.
- The language some of the staff used to describe people was not appropriate. For example, one member of staff described a person as ''like a 5-year-old child.'' Staff sometimes referred to people by their surnames only when writing records about people. This was not their preferred name.
- During the inspection we spoke with an independent interpreter to help us communicate with a person who was deaf and had limited speech. The interpreter explained how the person was not happy and did not always feel their needs were met. A member of staff listened to this and then was critical of the information the interpreter told us, stating that it was not true, and the staff knew the person better than the interpreter did. This response was dismissive of the information the person had shared with the interpreter.

Failure to treat people with dignity and respect was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had been consulted about their care. They had keyworkers, who were staff allocated to help coordinate their care and support. These keyworkers met with people to review their care.
- When people were in contact with their families, the provider consulted with these family members to ask for their views. However, there were no independent advocates arranged for people who did not have family representatives. We discussed this with the registered manager, so they understood why this was important to source this support.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated respectfully, because staff did not always afford them choices or speak about people in a respectful way. However, staff knew people well and sometimes spoke with fondness about them. People told us they liked the staff and had good relationships with them.
- We witnessed some kind and caring interactions when staff engaged with people and spoke in a gentle and positive way.

● There were plans to encourage people to be more independent with aspects of their care and lives. However, the culture at the service remained one where, as a rule, staff did things for people rather than allowing people time to be independent. For example, when one person asked to help make lunch, they were not supported with this, and staff made the lunch whilst they were out of the room.

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.

● People's communication needs were not always met. One person was deaf and used British Sign Language (BSL) to communicate. The staff were not trained in this. They said they were trained to use Makaton (another form of sign language) but none of the staff used this when communicating with the person during our inspection. We saw staff sometimes offered the person choices verbally without using any objects of reference. This meant they were not communicating clearly to the person.
● Staff told us the person was ''difficult to communicate with'', which demonstrated a lack of awareness that the responsibility was on staff to ensure clear and personalised communication.
● There were pictorial resources designed to help staff communicate with people. The staff did not use these with people during the inspection.
● There were some signs and notice boards within the home. However, these had not been completed or information on them was out of date. This was not in line with best practice and meant people did not have information about what was happening each day, meal choices or which staff were on duty.
● Information about where people should gather if the fire alarm was activated was displayed in a place which could not easily be seen by people using a wheelchair. There were 3 wheelchair users living at the home. Therefore, the provider had not ensured information was accessible and met people's needs.

Failure to meet people's communication needs was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had identified staff needed to be trained to communicate in BSL and had requested for this training to be provided.

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 supported to participate in a range of social, educational or leisure activities. Whilst there were some events which people enjoyed these took place once or twice a week for limited periods of time.
● On the day of our inspection, people spent most of their time at home either in their bedrooms, watching television or listening to music without staff support. The records of how people had spent their time each

day indicated this was what happened most days. This was not consistent with best practice for supporting people with learning disabilities and autistic people.
● There were not always clearly recorded goals and aspirations for people, and people did not receive support to improve their skills or pursue personalised goals.
● People were not supported to be active members of the local community. One person went out to places they enjoyed independently, but others were not supported with this to help broaden their interests and help them develop friendships outside of the home.
● People did not undertake vocational courses, voluntary work or employment.
● People were not given opportunities to participate in tasks around the house such as cooking, laying tables or cleaning. We spoke with the staff about this, and they told us they did these things for people. This denied them the opportunity to learn basic and important life skills and be part of the running of the service.

Failure to meet people's social, educational and leisure needs was a further breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People regularly attended some external activities such as church and day centres. The provider had started to contact other agencies to help broaden activity opportunities.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's needs were not always met in a personalised way. Staff interactions with people were limited and often task based. The staff had not explored ways to help people develop and meet personal objectives.
● Staff did not follow recognised good practice models of care and support for people with learning disabilities and autistic people. They did not provide personalised, individual support and adopted the same approach with everyone, which consisted mostly of directing people to watch television or listen to music whilst the staff attended to household tasks, paperwork or spent time talking together.
● People's sensory needs were not met, because the environment was not well maintained, there was limited information to help people make decisions and the staff demonstrated a lack of understanding and awareness of these needs.

Failure to provide personalised care and support was a further breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff had created care and support plans which were designed to show how their needs should be met. These included some information about people's preferences. The staff had reviewed these most months to assess how people's health, personal care and other aspects of their care were being met.
● The registered manager was aware people were not always receiving personalised care and support. They explained they were working with staff to improve the culture and to help people have more active lives, develop independent living skills, and create personal objectives. The registered manager explained this work was in the early stages and they understood a lot of improvement was needed.

Improving care quality in response to complaints or concerns
● There was a complaints procedure. People using the service, families and staff were aware of this.
● People using the service and their representatives knew who to speak with if they had any concerns.
● The registered manager had resolved concerns and made changes to improve the service because of these.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The culture did not value or promote people's individuality. People's needs were not always met, and the planned care was not designed to focus on their quality of life. Staff did not always treat people well or respect them.
- Notice boards on display still included the activity plan for a person who had died the previous year. Another sign denoting bedroom allocations, had the name of a person who had also died crossed out and replaced by the new occupant of the room and a second person who had died simply crossed out.
- Staff did not promote a community atmosphere or show respect that the service was people's home. At lunch time, people were served and ate individually. Staff did not sit with them or engage with them to make the experience pleasurable. After people had finished their lunch, the staff sat as a group to eat together. We overheard one member of staff speaking loudly that they needed a break. Sometimes when staff were approached by people, they told them to go and sit in another room rather than paying attention to the person. When people had expressed choices, these were not always respected.
- Staff were not able to, or chose not to, communicate clearly with one person who was deaf and sometimes spoke about people in a negative way.
- One person told us they did not feel safe in the home, that staff did not respect their choices and had not responded when they raised concerns about their medicines. When we discussed this with staff, they told us this was not true and showed no empathy or understanding of this.
- We received feedback from some staff that they felt there was a closed culture at the service where they were unable to raise concerns.

Failure to assess, monitor and improve the quality and safety of the service, including the quality of people's experience, was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The provider's systems for monitoring and improving the quality of the service were not implemented effectively. We identified breaches of 6 regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns spanned a wide range of service provision, including safety, quality of care, the environment, person-centred care, nutrition, dignity and respect. Staff did not understand or implement best practice guidance when caring for people with learning disabilities and autistic people.

● The systems for monitoring and mitigating risks were not implemented effectively. We identified health and safety hazards, infection control risks and poor systems for food storage. The provider had not identified these and not taken steps to put them right, despite carrying out their own audits of the service.
● Records were not always well maintained or clear. Books to record what people did each day were falling apart, had pages torn out and crossings out. Meaning these were not clear contemporaneous accounts. Records held in files and within the medicine cabinets included information about people who no longer used the service.

Failure to implement systems and processes to monitor and improve quality and to monitor and mitigate risk was a further breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they had identified where some improvements were needed and had started to address these. For example, we saw they had updated some records. They also told us they had met with staff to address some of the issues around practice.

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 understood their responsibilities under the duty of candour to investigate concerns, apologise and learn from these. They notified CQC of significant events and explained how they had responded to these.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The registered manager was suitably experienced and qualified.
● The provider had a range of policies and procedures which reflected good practice guidance and legislation.

Working in partnership with others
● The staff worked in partnership with other professionals to assess and monitor people's needs. There was evidence of consultation with health and social care professionals.
● The registered manager met with other managers with the organisation and locally to discuss best practice and learn from each other's experiences.

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 9 HSCA RA Regulations 2014 Person-centred care The registered persons did not ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered persons did not always ensure the nutritional and hydration needs of service users were met. Regulation 14

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons did not ensure that all premises and equipment were clean, suitable for the purpose for which they were being used

or properly maintained.

Regulation 15

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not ensure care and treatment was provided in a safe way for service users. Regulation 12

The enforcement action we took:

We have issued a warning notice telling the registered persons they must make the required improvements by 30 April 2023.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not effectively operate systems and processes to monitor and improve quality or to assess, monitor and mitigate risks. Regulation 17

The enforcement action we took:

We have issued a warning notice telling the registered persons they must make improvements by 31 July 2023.