Priory Education Services Limited

Priory Rookery Hove

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
Priory Rookery Hove is a residential care home providing personal care to 11 younger adults with learning disabilities, autism, or mental health conditions at the time of the inspection. The service can support up to 13 people. Priory Rookery Hove is a transitional unit. The aim of the service is to further develop people's life skills to give them independence and integrate them into the community.

Priory Rookery Hove was designed, developed and registered before 'Registering the Right Support' best practice guidance was published. If the provider applied to register Priory Rookery Hove today it is unlikely the application would be granted. The model and scale of care provided is not in keeping with the cultural and professional ideas of how services for people with a learning disability and/or Autism should be run to meet their needs. Improvements are needed to ensure the service develops in line with the values that underpin the Registering the Right Support and other best practice guidance. The building design fitted into the residential area and the other large domestic homes of a similar size. There were no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were discouraged from wearing anything that suggested they were care staff when coming and going with people.

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

People were not safe at the service. Policies in place to reduce risk were not always being followed or were not adequate to protect people from avoidable harm. Lessons were not learned when things went wrong, resulting in repeated events at the home where people were at risk. There were enough staff at the service to look after people, but staff worked long shifts and were often tired and stressed, which impacted on their ability to deliver care safely.

Staff had not received training in some of the specific mental health needs of people at the home. The home was not clean and was in a state of disrepair. Doors, radiators, cupboards, windows and a stair rail were all broken at the time of the inspection. People had food cooked for them by a chef on only three days a week, on other days support staff cooked. Support staff were not trained in nutrition or cooking. The communal kitchen which people should have been able to use was damaged, this left people to eat a repetitive diet with little choice.

Due to a lack of training staff did not always understand or respect people's equality and diversity. Staff and people told us there was not enough time to give people the support they needed. People were often bored at the home and one said there were times when they could not go out with staff as staff were supporting other people. People at the home did not always get on and the layout of the home meant people could not have the privacy they wanted unless they remained in their own rooms.

Complaints were not always responded to in a timely fashion and relatives had complained that issues

raised with the service went unanswered. The service had been without a full time positive behavioural support practitioner for some time. However, this role was now filled, and the service hoped to see a change in planning people's care.

The service was not person centred. The service was designed as a transitional unit to enable people to learn to live independently, however people were not learning new skills in preparation for leaving the home and some people had lived at Priory Rookery Hove for over five years. Staff worked well as a team together, but felt poorly informed by senior management. Senior management changes during the year and several staff vacancies had made this problem worse. New senior staff were making changes to communication with staff to rectify this issue. The provider was aware of the issues with management support and had put plans in place to improve staff support, however these had not been embedded and improvements had not yet been made.

People were not supported to have maximum choice and control of their lives. 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 did not always consistently apply 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. People had a lack of independence and care was not always person centred. The large number of people living at the home and the complex needs of some of the people meant that staff did not always have the skills to support people who needed it.

Following the inspection, we asked the provider to act to ensure people's safety. The provider said they would act. Despite this visiting health and social care professionals reported that incidents of self-injurious behaviour continued and people continued to be at risk of harm.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 4 April 2019) and there was a breach of regulation 12. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12 and was now also in breach of regulations 9, 13, 15,16 and 17.

Why we inspected
The inspection was prompted in part due to concerns received about safety of people at the home. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the full report for details.

You can see what action we have asked the provider to take at the end of the full report.

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

Follow up
We will request an action plan for 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.

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 of 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.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well led.	**Inadequate**

Priory Rookery Hove

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of two inspectors and an inspection manager.

Service and service type
Priory Rookery Hove 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.

The service had a manager registered with the Care Quality Commission. However they no longer worked at the service. A new manager was in position but was not yet registered with the Care Quality Commission. The registered manager 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
This inspection was unannounced on day one, a second visit was announced.

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

During the inspection-
We spoke with three people who used the service about their experience of the care provided. We spoke with 11 members of staff including the manager, operations director, managing director, positive support behaviour practitioner, senior care workers, care workers and the chef.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and asked for clarification about the management structure.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

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

Assessing risk, safety monitoring and management

- Despite policies being in place, events that put people at risk occurred frequently. Staff had become used to the incidents and they regarded them as inevitable, this meant that risks and subsequent harm to people were accepted rather than managed. When asked if people were safe at the home a staff member said, "No not really, everyone feels something bad is going to happen."
- People had their risks assessed. However, the risks were not managed appropriately. Staff were not trained in handling some of the serious risks people faced, such as self-harming.
- People's records were not clear. Where risks were assessed there were not always clear instructions on how to manage the risk, for example care plans lacked dated notes, it was unclear when a risk was assessed. Advice in one case suggested staff should 'intervene' if a person became aggressive and to call the police 'if necessary' but information about the type of intervention or at what point calling the police would be deemed necessary was not included in the plan.
- Risk assessments lacked information on the triggers that could lead to people becoming distressed or showing behaviours that challenged. While some staff knew people well, the file used by agency staff was not informative enough for them to understand people's needs and reduce risks to them and other people and staff at the home.

Learning lessons when things go wrong

- Lessons were not learned when things went wrong. The accidents and incidents folder contained information about incidents that occurred, some of which were serious and many of which were repeated. The column on the incident analysis form for 'learnings from the incident' was left blank.
- People at the home who had self-destructive tendencies, such as self-harm by cutting or ligatures, were not protected from harm. Reported incidents showed similar patterns leading up to the events, but no learning about triggers that affected the behaviour or how to minimise the triggers in future.
- Several people had been admitted to hospital on more than one occasion with the same issue and the police were frequently called for people who left the home with the intention of harming themselves.

Risks were recorded but not managed robustly. Methods of managing risks were not clearly stated. Lessons were not learned when things went wrong. This placed people at risk of harm. This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● There were some systems and policies in place to protect people from the risk of abuse. Staff had training in safeguarding when they arrived and understood what to do if they suspected a person was at risk of abuse. The manager notified the CQC of any safeguarding incidents, in line with regulation.
● The accidents and incidents folder contained details of incidents at the home. However, an incident where a person had become distressed and had told staff they had been spoken to in a way that upset them by a support worker contained no record of this allegation being investigated and this should have been documented. The service had failed to evidence how they had supported people where an allegation was made.

Systems and processes were not established or operated effectively to prevent abuse of service users. . This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People and staff at the home were not protected from the risk of infection. The home was not clean. Bathrooms and some communal areas of the home smelled of urine and bathrooms and toilets were not clean. The manager told us the cleaner visited on four mornings a week.
● Staff were concerned that during care for people that had wounds they may not be protected appropriately. A staff member told us, "Staff physically intervene when people have razor blades and have been getting cut, there's no support and we do not learn from mistakes. They say we will be given training, but we don't. We don't know what infections we could potentially get."

● People were encouraged to tidy up and clean their own rooms, but they did not always choose to do this. Staff told us they cleaned the communal areas when it was quiet, but they did not always have time.

Premises and equipment used were not clean, or properly maintained. The registered person had not, in relation to such premises and equipment, maintained standards of hygiene appropriate for the purposes for which they were being used. This was a breach of regulation 15 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough staff employed at the service to look after people, but staff worked long shifts and were often tired and stressed, which impacted on their ability to deliver care safely.
● A member of staff told us, "It feels there are enough staff on shift, if it's short then we struggle." And another staff member said, "We do have enough staff, maybe not if there is sickness or increased one to ones'.
(support for people)."
● Staff were recruited safely. The provider had systems in place to ensure staff were safe to work with people before they started working at the home. Staff references were checked, and the Disclosure and Barring Service (DBS) was used before staff were able to work at the home. The DBS allows employers to find out if a potential staff member has any criminal convictions or they have been barred from working with adults receiving care.

Using medicines safely
● Medicines were stored and administered safely. We saw a medicines round and saw staff administer medicines to people who came to the medicines room for their treatment.
● Medicine administration charts were filled in correctly and stocks of medicines were regularly checked and correct.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate.

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

Staff support: induction, training, skills and experience

At our last inspection we found training to be a breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection training was an area of practice that needed improvement. At this inspection this remained the case. Staff told us that training was not good. People at the home had complex mental health issues and staff felt untrained to deal with them effectively. A staff member said, "We had no specific training on suicide or self-harm. The Priory arranged training, but it was cancelled." Another staff member said, "We are guessing at the moment. We are not psychologists or counsellors, we are support workers." And "We had autism training but that was cancelled, I think we should have that sooner, there is a lot to learn about autism."
● Staff received online training, but this was not always completed. Training was lacking for specific conditions of people at the home. When asked about the training a staff member told us, "I feel it is dreadful and I have brought it up loads of times." And another member of staff said, "I didn't think my training was very good. I just had a day with a trained person then they left and I was left to get on with the job."
● Staff felt well supported by other members of the team, but felt that senior management were not supportive enough and they were not aware of the issues at the home. The manager and the operational manager were implementing new areas of training and identifying training gaps for current staff, however this was not currently in place.
● Staff had a five-day induction period and were assessed before starting work permanently at the home. Staff had files to record their initial recruitment and training. We did not see paperwork to show that all staff had completed the five-day induction, however despite this, some of these staff were working unsupervised at the home.

Staff were not receiving adequate training in specialist areas necessary for them to support people safely. This placed people at risk of harm. This was a continued breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Much of the home showed signs of damage. Walls and doors had dents and chipped paint. There were broken radiators and damaged cupboards in the dining area and a broken radiator in the hallway. These broken items had sharp edges and were not safe. Damage had been reported a month before, but was still not repaired.

● Staff told us blinds and curtains had been damaged by people at the home or had been removed for their safety. However, we saw blinds with cords in the communal computer room, which could place people at risk. Safety was not consistent for people. Broken windows in the 'quiet lounge' had not been glazed after an incident. The manager told us they would be mended. However, they were boarded up at our next visit rather than glazed. The manager told us the maintenance staff had left and maintenance was contracted out to external providers.

● The manager told us the damage was caused by a small number of people. However, the damage affected everyone at the home. People were not happy about the damage, a person told us, "I like it here, without the person smashing it up."

● The décor of the home did not meet people's needs. The home was sparsely decorated. Curtains were missing from a front room window. We were told there was film on the window to prevent people seeing into the house. However, we saw into the room from the street when we left. People had no privacy in this room, but may have believed they did.

● There was a lift at the home which had been out of order for several years. People were able to use the stairs. However, a hand rail on the stairs was broken and the sharp ends covered with tape as a temporary fix.

The provider had failed to ensure the premises were safe to use for their intended purpose.. This placed people at risk of harm. This was a breach of regulation 12of 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

● People had their needs assessed and their care plans reflected this. However, the care plans contained pages out of chronological order, and contained out of date information. A briefer set of care notes for agency staff to read were missing important information, such as people's photographs and dates of birth, or were undated. This meant that care given did not always reflect the needs of the person.

● People had assessments as their needs changed, but care was not changed to reflect this adequately. Where people had started to self-harm or attempt suicide, care plans recorded the changes and risk assessments, including what steps to take to keep people safe, but staff had no training in the extra needs people had. The reasons for the changes in behaviour were not addressed.

● We did not see evidence that NICE (The National Institute for Health and Care Excellence) guidelines were being followed in the care of people who were self-harming. People were referred to their GPs or to the accident and emergency department when they were unwell, but people were not always receiving the care they needed.

● Staff recording information in people's care plans did not use people's preferred way of identifying. A lack of training in transgender awareness for staff meant that staff were not aware of the importance of getting details correct. Notes showed that for some people this was a trigger for their distressed behaviour.

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

● A chef cooked for people on three days a week, but on other days support staff were responsible for cooking meals. Support staff had no training in cooking or nutrition. Agency staff were often asked to cook as they did not know people in the home well and it was seen as a better use of their time. A staff member said, "Staff are trained in food handling, but staff are taken off the floor to do the cooking. Staff have

complained about this. I think they can afford a chef every day. Not all staff are good at cooking, staff are support workers, not chefs." The operational manager told us they would place an advert for an extra chef immediately as they had not been aware that the service lacked a chef on four days a week.

● The main kitchen was clean, but a second, communal kitchen which should have been for people to prepare and cook their own meals, was in dangerously poor repair. There were broken cupboards and one of two ovens was dirty and missing a door, this had not been repaired since the last inspection.

● People could choose to eat food prepared at the home, to cook for themselves or to buy and eat food outside of the home. People were free to make unwise choices and for some people this was around food. Staff tried to encourage people to eat well. A person told us they liked to drink coke and eat crisps and listen to the radio. They said, 'That's my life now." Despite this, evidence showed that improvement was needed to support people to maintain a balanced diet.

Staff working with other agencies to provide consistent, effective, timely care

● Staff worked with other agencies, referrals were made and requests sent as necessary. However, we saw that in some cases local authorities or commissioning groups were unable to move people to more suitable accommodation when asked. This had impacted on other people at the home. The provider was in regular contact with the local authority to accelerate the moving process.

● Police were regularly called to the service. However, it was unclear if the manager had explained people's needs well enough to them for them to be of help. A staff member told us, "I don't know what the service is. Because we are not a secure unit if people try to abscond, the police wonder why we are not adapting the environment to make it safe enough."

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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff did not fully understand DoLS. On at least one occasion people were told their DoLS could not be changed, in reality a person does not have to be deprived of their liberty for the duration of the authorisation. The restrictions should stop as soon as they are no longer required.

● DoLS information, including any conditions, were recorded in care plans. However, some people at the home had a DoLS in place despite evidence in the care plan to suggest they had capacity. People living under DoLS were supported by staff when leaving the home, and were prevented from leaving the home alone by code locks on doors and gates. People that were free to leave had access to the codes.

● Staff had training in the MCA and ensured that people had choice about their care where possible.

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

- People were supported to seek help for any medical issues they had. A person told us they had an appointment at the hospital and that staff would go with them if they wanted.
- People visited their GPs and this was documented in the care plan.
- People were knowledgeable about their medicines and told us about them and why they took them.

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.

Supporting people to express their views and be involved in making decisions about their care

- Staff did not have enough time, training or support to provide care in a compassionate and personal way for people. Staff told us there was rarely time to do extra things with people. A staff member told us that among staff, "Morale is low." They also commented, "Residents are happy, but some can get bored."
- Staff felt that people wanted more support than staff were able to give and this let people down. A staff member told us, "Some people have really complex cases. Not enough is going into aiding people, we just help them live. They don't get enough input from outside."
- People were able to express their views about the care they received. However due to people's complex needs their wishes were not always catered for. For example, if people wanted support when they left the home this was not always possible due to the number of staff. A person told us, "Sometimes I can't go out because three staff have gone out with two residents."

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

- People's dignity was not always respected, staff did not always address people in the way they requested. This had led to people becoming extremely upset.
- People's privacy was respected, however some people needed constant observation for safety.
- People's equality and diversity was not always respected. Staff had no training in specific protected characteristics of people at the home, and care plans to help staff know about people contained reference to people in incorrect genders. Training was organised for staff in response to our concerns about a lack of specialised training to support people. Training dates had not been arranged at the time of the inspection.
- People told us they got on with some staff at the home. A person told us, "I like staff I can gel with. I get on with the agency (staff) and one of the night care workers can work wonders."

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 requires improvement. At this inspection this key question has deteriorated to inadequate.

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

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

- People did not always have choice. Where there was a risk that people might become overly attached to specific staff members this was documented in the care plans but with no guidance, which left staff to manage this themselves. A staff member told us, "People are not supposed to be able to select who they go out with." They told us how this had caused a person to become distressed and break things when they could not go with the support worker they chose.
- People with complex needs were not supported by staff with the required levels of skills and knowledge this left people at greater risk of being provoked into distressed behaviour. People were not supported to understand the risks and benefits associated with their choices and staff did not understand either the reasons people were at the service or what they hoped to achieve. A staff member told us, "Keyworkers are supposed to look at the care plan. But there is no framework to check up on the progress at a supervision to see if progress is being made."
- People's care plans did not have agreed goals. A lack of planning for people's futures at the service and beyond left people with sense of why they were at the home or if they would leave. Some people had ideas to own their own property, however these ideas were not always documented and staff saw them as unrealistic. People were not supported to plan realistic goals.

People were not supported to understand risks associated with their choices and people did not have clear goals documented. This was a breach of regulation 9(3)(b) Person Centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- Care quality was not improved in response to complaints. The service and the CQC received complaints about the service. Issues raised had not been solved or addressed, for example people making threats to other people in the home were not always addressed by staff, who regarded them as something to be recorded but not acted on.
- The décor and damages in the home had also been the subject of complaints but had not be mended in a timely manner. Leaving areas of the home unsafe with sharp metal protruding from walls.

Complaints were not acted on in a timely manner. Repairs were not carried out promptly after complaints were received leaving people at risk of harm. This was a breach of regulation 16(1) Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Support staff spoke to people in ways they understood. No one at the home had an impairment that required them to have documents provided in alternative formats. Complex issues were explained to people by the staff. A person told us, "I can talk to the manager if she's not too busy."

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 supported to take part in activities they enjoyed. However, activities within the home were limited. People were able to participate in painting and art activities which one person told us they enjoyed. Another person said, "There is art but I'm not an art sort of person."

● Some people told us they had 'gig buddies' and were able to go out to local events in the evening. Gig Buddies is a project that pairs up people with learning disabilities and/or autism to be friends and to go to events together. A person told us that they were involved in the local disability football league who met and played once a month and that they went out with their buddy, they told us, "I go to the cinema, crazy golf and gigs."

End of life care and support

● Where appropriate people had their end of life preferences noted in their care plans, but for people at risk of suicide or self-harm the subject had not been safe to talk about.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

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

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

- The aims of the service were not clear. Staff told that people should learn to be independent at Priory Rookery Hove in preparation to move into a home of their own. However, some people had lived at the home for over 10 years. The managing director told us the action plan for the service included looking at the vision of the home. They said, "Moving people on is not happening. We should assess people, look at how long they plan to live here, and what are the goals they have."
- Staff told us they did not know if the provider or manager were doing anything in response to repeated incidents of violence at the home. Staff told us that communication was poor. A staff member commented, "The lack of communication between management and staff is an issue, it can be frustrating." We fed this back to the manager during the inspection and they told us they would ensure staff were kept informed of action plans in future.
- Managers were clear about their roles. However, a high turnover of staff and gaps in senior managers' positions being filled had resulted in quality performance deteriorating and in risks being recorded but poorly managed. A staff member said, "Some people have lost the heart for the job because they've been involved in some nasty stuff. Morale has suffered as we are all pretty sensitive."
- Staff teams worked well together and told us they got on well. However, there was a risk that staff were teaching other staff rather than staff being trained formally. A staff member told us, "None of us have special training, in autism, or behavioural issues. We can read up on things."
- The new manager was being supported by the senior management team and the provider. However, at the time of our inspection improvements had not been made to the service.

Systems were not in place to mitigate the risks relating to health, safety and welfare of service users and others who may be at risk which arise from the carrying out of a regulated activity. This placed people at risk of harm. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 service was not person centred. People did not have choice about who else lived at the home and in

many cases people did not get on with each other well. People's distressed behaviours were often triggered by other people who lived at the home or by staff interacting with other people, causing jealousy. Notes were made in the incident records to show this, but changes were not made to drive improvement for people.

● People were not able to be involved with the running of the service. People were not consulted about new people coming to live at the home and were not able to meet them before placements were decided. People who were triggered by changes were not able to cope with the number of new people who had been admitted to the home at one time and this had affected their behaviour. The distressed behaviour had affected staff and other people at the home.

● Staff were unsure of the visions and purpose of the service and felt unable to have input in its development.

Working in partnership with others

● The service did not always work closely with relevant professionals for people's complex mental health and care needs. The manager and other managers within the Priory group worked together to look at problems and referred issues internally to other members of the team. The service employed their own positive behavioural support (PBS) practitioner who was keen to improve the care at the home. They said, "I will work with staff if I see ways they work that aren't working well. I will be writing PBS strategies and working with the staff on those."

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

● Managers understood the regulatory requirements and the need to send information of adverse incidents to the CQC without delay. However, notifications that should have been sent to the CQC were not always sent on time. In the months prior to the inspection there had been an increase in the number of notifications received by the CQC.

● The provider knew their responsibilities under the duty of candour, but families had complained that when they contacted the manager via email they did not always receive a reply.

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 How the regulation was not being met: The provider had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9(1), 9(3)(a-f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users. The provider had not ensured that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Regulation 12(1), 12(2)(a-d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes were not established or operated effectively to prevent abuse of service users. Regulation 13(3), 13(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

How the regulation was not being met: Premises and equipment used were not clean, or properly maintained. The registered person had not, in relation to such premises and equipment, maintained standards of hygiene appropriate for the purposes for which they were being used. Regulation 15(1)(a-e), 15(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints How the regulation was not being met: The registered person had not establish or operated a robust, accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(1), 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes did not enable the registered person to assess, monitor or improve the quality and safety of the services provided in the carrying on of the regulated activity. Systems to mitigate the risks relating to the health, safety and welfare of service users and others were not robust or adequate. Regulation 17(1), 17(2)(a-f)