Autism Hampshire

Autism Hampshire - 102a Brockhurst Road

Inspection report

102a Brockhurst Road
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
102a Brockhurst Road is a residential care home providing accommodation and personal care to people with a learning disability and autism. The service can support up to four people. At the time of the inspection four people were being supported.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability with the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

Based on our review of key questions safe, effective and well-led, the provider was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

The service was not maximising people's choices, control or independence. There was a lack of person-centred care and people's human rights were not always upheld. A lack of timely action by leaders to ensure the service was well staffed and safeguarding incidents were responded to meant people did not lead inclusive or empowered lives.

People did not receive a service that provided them with safe, effective, compassionate and high-quality care. The provider had not established an effective system to ensure people were protected from the risk of abuse. Risks to people's health and wellbeing had not been monitored or mitigated effectively. People were at risk of harm because staff did not always have the information they needed to support people safely. Safety concerns in relation to the environment were identified. The provider had not ensured there were sufficient numbers of competent and skilled staff to support people safely.

People were not always provided with a varied and nutritious diet based on their individual preferences and to promote their health and wellbeing.

The principles of the Mental Capacity Act 2005 were not understood and applied. 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.

Leadership was poor and the service was not well-led. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements.

The provider did not have enough oversight of the service to ensure that it was being managed safely and quality was maintained. Quality assurance processes had not identified all of the concerns in the service and where they had, sufficient improvement had not taken place. Records were not always complete.

People were not always given the opportunity to feedback about care or the wider service. Indicators of a closed culture were identified.

Following the inspection, the nominated individual provided us with an action plan to address the issues we had identified.

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

Rating at last inspection
The last rating for this service was good (published 17 December 2020).

Why we inspected
The inspection was prompted in part due to concerns received about the safety of people and a lack of leadership at Autism Hampshire – 102a Brockhurst Road. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Autism Hampshire – 102a Brockhurst Road on our website at www.cqc.org.uk.

We have found evidence the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, risk management, staffing levels and training, the premises, the mental capacity act, person centred care, nutrition and hydration and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Autism Hampshire - 102a Brockhurst Road

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.

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
This inspection was completed by three inspectors.

Service and service type
102a Brockhurst Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 the inspection the service did not have a manager registered with the Care Quality Commission. A new manager had been employed and commenced working at 102a Brockhurst Road one week prior to the inspection. This meant the provider was 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.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 reviewed notifications the provider had sent us. Notifications are sent when a significant event has happened in the service. We used all of this information to plan our inspection.

During the inspection
We carried out observations of people's experiences throughout the inspection. We spoke with five members of staff including the senior manager, manager, deputy manager and two care workers.

We reviewed a range of records. This included two people's care records and four people's medication records. We looked at a variety of records relating to the management of the service, including policies, procedures and audits.

After the inspection
We continued to seek clarification from the management team to validate evidence found. We looked at training data, quality assurance records, staff recruitment records, staff rota's and additional records in relation to the management of the service.

We received feedback from two health and social care professionals, spoke with three relatives of people who lived at the service and four care workers. We also spoke with the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 Good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The provider had not ensured there were enough numbers of competent and skilled staff available to support people safely.
- On day one of the inspection we asked the senior manager and manager what people's assessed staffing levels were and who was responsible for completing staff rotas. The manager and senior manager were unable to answer this. The staffing levels in place appeared to depend on staff available, rather than meeting the needs of the people. Therefore, we were not assured that people were receiving the level of staff support they needed.
- On day two of the inspection we observed one person who was showing signs of distress and were attempting to leave the service unsupported. We had been told by staff this person can present with behaviours which put people and staff at risk of harm and on occasion actual harm to staff. There was only one staff member available to support this person as they attempted to leave the service, the other staff member was supporting another person. The staff member had no immediate access to additional support to manage this potentially volatile situation which could have resulted in significant harm.
- The management team told us usually staffing levels within the home consisted of two or three staff (usually three) in the morning, two or three staff (usually three) in the afternoon and two at night. This was disputed by all but one of the staff members we spoke with. A staff member said, "There has not been more than two staff in the time I have worked here." Another staff member told us, "There are only two staff on, they [provider] say that is all we are funded for." A third staff member described the staffing levels as, "totally inadequate."
- On review of the staff rotas for the period of 1 September 2021 to the 4 December 2021 it was noted frequently there was only two staff available to support people. Additionally, the rota identified a high level of agency staff were used to cover shifts and these staff sometimes worked alone. This meant people were not always supported by staff who knew them well or understood how best to meet their needs and ensure their safety.
- Following the inspection, we contacted the funding authority for two of the people living at 102a Brockhurst Road and were told these people were funded for 35 one to one hours per week. There was no evidence available that demonstrated these hours were being provided.
- People's level of needs had not been reviewed or reassessed to ensure the current staffing levels were appropriate.

The failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The recruitment of staff was safe. Appropriate recruitment practices had been carried out. This included

completing checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse

● Some practices in the service were restrictive, this placed people at risk of institutional abuse.

● Two people's movements were restricted by using timers. This meant when these people requested something a timer would be set for varying periods of time before this was provided or agreed. There was no detailed documentation as to why this restriction was in place. When we asked the management team why the timers were used we were told it was to manage people's expectations however, we could not establish why these people's expectations required managing and there was no evidence available which demonstrated the use of these timers were effective. The management team told us they were currently reviewing the use of timers after it was previously highlighted to them and they were considering ways to address this.

● The training matrix demonstrated most staff had received training in safeguarding adults from abuse. However, when we discussed this with staff members, only one staff member we spoke with confirmed this training had been received. Most staff spoken with were able to demonstrate they had some understanding of how to recognise abuse and the action to take if they had concerns.

● Robust systems were not in place to support people to manage their finances. This placed people at risk of financial abuse.

● We were not assured that all incidents which could constitute a safeguarding alert or concern were being identified by the service. This was because the system to review and monitor incidents was not effective.

The failure to safeguard people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection we told the local authority safeguarding team of our concerns. In conjunction with other professionals, measures were put in place and planned for to support safety in the service. We also told the nominated individual of our concerns. Following the inspection, the nominated individual sent us an action plan. This detailed ongoing plans to ensure safeguarding concerns would be addressed. This meant the immediate risk of harm and abuse to people was reduced.

Assessing risk, safety monitoring and management

● The provider had failed to ensure the safety of people. Risks to people were not managed and mitigated effectively.

● People's care records and files contained extensive records about people and their needs, however the information within these files did not contain detailed and up to date information about these needs and how they should be managed. Additionally, at times this information was conflicting. For example, in one area of a person's care file it mentioned the person was on restricted fluids, yet in another area it stated they could drink as much tea, coffee or water as they wished. Following the inspection, the provider confirmed they will be updating and developing more detailed and effective care and support plans for people.

● Robust and detailed risk assessments were not always in place to provide guidance to staff on how to mitigate and manage the risks relating to people's needs. This meant we could not be assured people's needs were appropriately managed.

● One person demonstrated they experienced regular high levels of anxiety and showed signs of frustration. Although this person had some information within their care record of what support they required to manage these behaviours, information was not robust. The information available did not provide staff with detailed de-escalation strategies they could use to reduce the risk of anxiety and behaviours that challenged others. This meant the person behaved in a way that was challenging for staff to cope with. The lack of

effective strategies to support this person left them and others at risk of harm.
● All staff spoken to felt the care plans were unhelpful and did not provide them with the information required to help ensure people received the care they required.
● We found a number of safety concerns in relation to the environment.
● On day one of the inspection we identified areas of the environment which could pose a risk of harm to the people living at 102a Brockhurst Road. For example, in one person's bedroom there was a large metal sheet which was fixed to a wall with glue. This sheet had become partially unstuck and could cause harm to people from entrapment or injury should the sheet fall.
● Additionally, in one person's bathroom, a sheet of plaster board had been fixed to the wall with large screws. These screws were sticking out and could easily be removed and cause harm to people. We brought this concern to the attention of the management team however, on day two of the inspection no actions had been taken to address these concerns. Following the inspection, we received contact from the management team, confirming these issues had been addressed.
● Environmental risk assessments, general audit checks and health and safety audits had not been completed consistently. Where these had been completed, concerns identified were not always acted on.
● We could not be assured all staff had received fire safety training or that action was taken in a timely way when fire safety concerns were identified.
● Water temperature checks had not been completed in accordance with best practice guidance and we could not be assured water samples were routinely tested for Legionella. The manager provided us with a copy of the last completed legionella risk assessment with was completed on the 10 June 2020. This completed risk assessment identified there were 13 urgent remedial actions required to control serious risk. The management team were unable to confirm or provide us with any evidence actions had been taken to address these issues. This meant that people remained at continued risk of legionella. The senior manager agreed to request an urgent assessment from an appropriate professional in relation to legionella.

The failure to ensure people were provided with safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We found some areas of the home were poorly maintained, so could not be effectively cleaned.
● The provider had not ensured regular cleaning had taken place which was evidenced by our observations. Some areas of the home were dusty, and walls were stained. Additionally, robust cleaning systems were not in place. For example, there were no systems in place to ensure deep cleaning was completed.
● Infection control audits had not been completed consistently and were not robust. Where concerns had been identified in these audits' actions had not been taken. For example, the audits completed for the months of March, April, May, July and August 2021 all highlighted infection control and cleanliness concerns in relation to the kitchen, however no action had been taken.

These issues have been considered in the effective and well led sections of this report.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong

● The provider did not have a robust system in place to monitor accidents and incidents, or to identify any patterns or trends. Although we saw evidence some incidents and accidents were recorded, we could not be assured this was completed for all incidents and accidents. Additionally, there was no evidence that following incidents and accidents investigations had taken place, analysis of why these incidents may have occurred or that measures had been implemented to reduce the likelihood of this happening again.

Using medicines safely

● We could not be assured medicines were always available to people. For example, when we viewed the completed medicine audits, 17 completed audits between 3 March 2021 to 19 August 2021 all stated, 'some prescription toothpaste unavailable due to restricted dentist appointments.' There was no information available which demonstrated any action had been taken to address this.

● People were provided with 'as required' (PRN) medicines when needed. PRN plans were in place, which included information in relation to when these medicines should be given, the expected outcome and the action to take if desired outcome was not achieved.

● There were systems in place to ensure that medicines were securely stored.

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.

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.

● Where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions. These included decisions relating to money management and restrictions on movement. Prior to making decisions on behalf of people, staff had not always completed the required two-stage test to assess the person's capacity to make the decision or consulted with their family members. Therefore, staff were unable to confirm the decisions made were necessary or had been made in peoples' best interest.
● As highlighted in the safe section of this report, some people living at the home were subject to restrictions upon their rights. Restrictive practices are when people are prevented from doing something usually in the form of restraint in order to keep them safe. Information was not always available in people's records to explain why restrictions were in place. The MCA had not been followed and appropriate DoLS applications had not been made to ensure this practice was lawful.
● All people living at the home were under continuous supervision and control. When this was discussed with the senior manager and manager, they were unable to confirm if any of the people living at the home were subject to a DoLS. We reviewed three people's care records and identified one person had an authorised DoLs in place. For a second person we found a copy of a DoLS authorisation which had expired over one year prior to the inspection. The management team were unable to confirm if this person had a valid DOLs in place. Following the inspection, we received information from the management team stating they had located a DoLS for this person. No application had been made for the third person. This meant this

person's legal rights had not always been upheld and the service had not been working in line with the principles of the MCA.'

Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a breach of regulation 11 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014 (Part 3).

Adapting service, design, decoration to meet people's needs
● We found some areas of the home were poorly maintained, so could not be effectively cleaned. For example, the worktop in the kitchen needed replacing and paint was peeling off walls in some rooms, including bedrooms and communal areas.
● Areas throughout the home were in a poor state of repair. There were holes in the walls, peeling paint, stains on the walls and ceilings and loose door handles. The senior manager told us there were plans in place to address these issues and improvements were due to start on the 4 December 2021. On day two of the inspection (7 December 2021) these issues remained.
● Three of the four bedrooms viewed did not provide a pleasant space for people to spend time in and relax. These bedrooms had not been personalised to people's individual tastes and interests. They were in a poor decorative order, lacked personal possessions and contained broken furniture in a poor condition.
● Living in an environment as described above, could have a negative impact on people's emotional, psychological and physical health.

The failure to ensure the environment was properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the nominated individual sent us an action plan detailing how the service planned to address the environment issues highlighted.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We could not be assured people's individual needs or the appropriateness of the environment for people was considered prior to them moving into the service.
● Approximately two weeks prior to the inspection a person moved to the service from another service owned by the provider. There was no period of transition for this person, the move happened quickly, without planning or discussion with the person. Two staff members confirmed how the move for the person was not planned and the impact this had on the person and other people living in the home.
● Staff did not feel they could always provide people with the care they required in line with their personal preferences and choices. A staff member said, "We don't really have time to ask them [people] what they want, we don't have enough staff to support them anyway."
● We could not be assured people's individual health needs were being met or mitigated.
● Throughout the inspection we observed a person continually touching areas in and around their mouth. We were told by staff members and the management team the person was on restricted fluids and did this because they wanted a drink. However, we noted this person did not have good oral health. When this was discussed with staff, we were informed this person had recently seen a dentist although the management team and staff were unable to tell us when this occurred or what the outcome of this appointment was. Therefore, we could not be assured this person was not in pain.
● We could not be assured people received regular health checks. For one person it was noted on their health care log they had last received their annual health check in May 2019 and their last annual diabetic

review was in October 2019. When this was discussed with staff, they were unsure if, or when additional checks had been completed or what the outcome of these checks were.
● Following a person's diabetic review completed in October 2019 we found a handwritten note in this person's care file which stated, '[Person] has been advised that their cholesterol is high and is to avoid fatty foods.' There was no evidence this had been addressed or actions taken to manage or mitigate this risk to their health.
● The manager, senior manager and some staff were unsure what people's physical health needs were. We asked a staff member how they should monitor and manage specific health conditions for a person, and they were unable to tell us. This meant we could not be assured people's health needs were appropriately managed, assessed in a timely way or actions would be taken which followed professional advice.

The failure to provide people with person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● We could not be assured that people were supported to eat a varied and nutritious diet.
● One person's food record highlighted that over a period of 26 days they received burger and chips on eight occasions; once twice in one day and five meals of fish and chips. There was no evidence nutritious breakfasts and snacks were provided. According to the persons food chart, during this 26-day period, the person had received fruit on three occasions and vegetables on six occasions. This person was reliant on staff to provide access to snacks and meals and had specific health needs which could be impacted by their diet. This meant the person was not being supported to sustain good health.
● Within two people's care records it was noted these people required their weights to be monitored monthly. On review of one of these weight charts we identified from the 6 September to the 15 November 2020 this person had gained a significant amount of weight. Prior to the start of this record a monthly review was completed in August 2020 by a member of the management team. This review highlighted weight gain during the month of August 2020 and stated, 'they would make sure [person] had very healthy snacks and balanced meals.' Due to continued weight gain and a review of the person food intake record we were not assured adjustments had been made to the persons diet to support healthy eating. Furthermore, we could not find evidence the persons weight continued to be monitored beyond the 21 December 2020.
● We could not be assured people were provided with enough fluids. One person who frequently expressed the wish to drink was on restricted fluids due to a physical health need. This person's fluid allowance was documented as an allowance of 2500ml daily. On review of their fluid intake records it was noted that frequently the fluids provided were below the restricted level allowance. For example, on the 24 November 2021 the total of fluids provided were 750ml.
● People's specific dietary requirements were not always understood by staff or detailed clearly within their care plans.

The failure to meet a person's nutritional and hydrations needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider's training records showed not all staff had received adequate training in a timely way to equip them to do their roles, safely and effectively. For example, some gaps were noted in the completion of safeguarding training, MCA training and health and safety training. Staff confirmed they had not received all the training they required.
● Staff had mixed views on the quality of the training they received and the access to training. A staff member said, "It [training] is all online. I have not done it all as not had time due to staff shortages." Another

staff member said, "I did safeguarding training. The whole thing was a bit rushed as they were trying to fit it all in though." Two staff also commented training often had to be cancelled at the last minute due to staff shortages. However, one staff member told us they felt they had appropriate training and another staff member commented an increase in training over the last few weeks.

● From our observations and conversations with some staff it was evident although staff wanted to provide safe and effective care to people, they lacked the skills, knowledge and understanding of people's needs and how to safely and appropriately manage these needs.

● There was a process in place for all new staff to complete an induction to the service and a period of shadowing experienced staff members before being permitted to work unsupervised. However, this was not followed. One staff member described their induction as, "rubbish." Another staff member told us, "I was left with service users I did not know anything about or if there were any risks. It is just awful as there is no system to be sure staff know what they are doing or can keep themselves or people safe." Two other staff members stated they did not complete a full induction when they started at the service due to staff shortages.

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During and following our inspection process, the nominated individual told us of their plans to ensure people were supported by sufficient numbers of suitably skilled and competent staff. This included additional training.

● Staff described a historic lack of supervision and support from the management team. However, all staff spoken to had confidence they will be better supported, respected and valued now the new manager and deputy manager were in post. All staff spoke positively about the new management team.

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

- We identified there had been an historic lack of leadership, direction and oversight. This lack of leadership had impacted on the running of the service and the safety of the care people received.
- Systems and processes were not operated effectively to ensure the service was safe and people were receiving high-quality care. This led to multiple breaches of regulation and placed people at risk of harm as outlined in the safe and effective domains of this report.
- There was a lack of robust governance processes and systems in place to help ensure the safe running of the service. Without these systems, the provider and management team could not be proactive in identifying issues and concerns in a timely way and acting on these. The concerns found at the inspection included but were not limited to, staffing, training, care records, risk management, DoLS, consent and the mental capacity act, environment safety concerns and the lack of person-centred care.
- The provider failed to follow their own governance policy to ensure quality and safety. Some audits were carried out, but these were not done in line with their policy because they were not completed consistently or effectively and did not drive improvement.
- The provider failed to operate effective systems to manage risk. From our observations, review of incident and accident reports and from information provided by the management team and staff we identified safety concerns and safeguarding incidents had occurred. These placed people and staff at risk of harm. However, safeguarding incidents and concerns had not been investigated, analysed or acted upon effectively to inform ongoing practice and ensure people's safety.
- The provider used an overarching quality audit which incorporated all aspects of service delivery. This consisted of assessment, action and review. The initial assessment had been undertaken by the registered manager in February 2021 and reviewed by a quality manager in April 2021. This identified a number of shortfalls at 102a Brockhurst Road, including gaps in MARs, unclean areas in the home and people's risk management plans not being completed. This was reviewed in October and November 2021 and action had not been taken to address all the previously identified issues. Furthermore, deterioration in the service was identified. We found most of these issues were still ongoing at the time of our inspection. This demonstrated the system had not been effective in ensuring the service was safe, people received high-quality care or drove necessary improvement where concerns were identified.
- External agencies had visited the home to complete audits. However, this also did not drive the provider to make necessary improvements. For example, we found some of the same issues at our inspection that were identified in an environmental health review in 2019. We could not be assured action had been taken as

highlighted following the legionella risk assessment completed in June 2020.
● Following concerns raised with the provider in July 2021 a full culture review was undertaken by the provider, some concerns were identified and addressed. However, during the inspection we identified the culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control and independence over their lives. Care was not person-centred and the poor leadership by the provider did not ensure people led empowered lives.
● People did not always receive person-centred care or supported to be empowered.
● The time staff were required to spend supporting a person with heightened anxieties meant time was reduced on undertaking personalised and meaningful activities to enhance well-being. For example, one staff member told us, "The lack of staff impacts on us being able to do our job well and support people safely and so they can enjoy activities."
● There was no evidence that people were given opportunities to partake in new experiences, learn new skills and gain independence.
● Staff told us the service has historically not been well-led. A staff member told us, "The providers don't care about the people or staff, they really don't. They are just not interested." Another staff member said, "We have lacked organisation and have been really unsupported."
● There were several indicators of closed cultures within the service. For example, the service supported people who were less able to speak up for themselves without good support from the service. People had not been safeguarded against harm and abuse and the principles of the MCA had not always been followed. A lack of suitable induction and training was identified, and staff worked excessively long hours. The governance of the service was poor, and staff felt unsupported.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the nominated individual sent us an action plan detailing how they would improve the governance of the home and how they planned to promote a person centered and positive culture within the service. They told us the new manager and deputy manager would provide effective leadership and have sufficient oversight from the provider. The action plan also detailed how quality assurance processes would be strengthened.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunities to discuss their individual care needs or wider issues in the home. We asked a staff member whether people were supported to make decisions about their care, and they replied, "They [people] do not get to have their own voices heard."
● Although relatives made some positive comments about the care provided to their loved ones and the staff, some of the comments made demonstrated a lack of opportunity to be involved in their loved one's care. For example, one relative told us, they, didn't know what [person] does in relation to activities. They added, "They [staff] don't send photos or keep me updated with what he's doing." Another relative said, "They [staff] used to ring me to tell me if anything happened, but it hasn't happened lately. They [staff] used to tell me if he was unwell, but haven't for a while, so I think he's ok?" A third relative said, "I used to have a letter to tell me if there were changes, but I've not had one for a long time" and, "I haven't been involved in any reviews." Following the inspection, we were informed by the provider, interactions with relatives had been reviewed and new systems were being implemented to support engagement.
● Staff told us up until the last two weeks they had not felt valued or listened to by the previous management teams and provider organisation. Staff shared with us information about safety incidents and

injuries they had sustained while carrying out their day to day duties. One staff member described how they sustained an injury while at work, but this was dismissed by the management and the blame was put on the staff member. This staff member said, "There is not any information in care plans or anywhere about what we need to do, it is not safe at all." They added "When you work with people with very complex needs and behaviours, some incidents can happen, but they should not be happening this frequently, this regularly. We should be trained and supported to have the skills needed to support people safely and enough staff." Other staff members did confirm that they had recently received behavioural management training the keep people and themselves safe.

● Professionals told us the provider did not always work in partnership with them. One professional told us, "I don't remember when the service last made contact with me to discuss [persons] needs."

The failure to seek and act on feedback was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were hopeful things would improve with the new management team in place and spoke positively about the work they had achieved so far. A staff member said, "The new managers are working really hard, so I really hope things are going to improve." Another staff member told us, "It has been really poorly managed but for the first time since I've been here, I feel like we have a good management team with [names of senior manager, manager and deputy manager]." A third staff member told us, "The new managers are really approachable and listen to us, I do feel supported by them."

● During the inspection the senior manager, manager, deputy manager and staff were open and honest with the inspectors.

Following the inspection, the nominated individual sent us an action plan detailing how they would improve partnership working and engagement with others.

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 senior manager and manager demonstrated an understanding of their responsibilities in relation to duty of candour requirements and described actions they would take to ensure this was complied with.

● Feedback from staff and the management team described an historic lack of transparency and action when things had gone wrong previously. For example, one staff member told us, "We are told to record incidents and send to head office, then head office deny they have received it. Nothing happens as a result." Another staff member said, "I have raised concerns with the provider, nothing is ever done." A third staff member told us, "What the process should be is we record it on incident record and then it gets sent to [nominated individual] then safeguarding informed if needed, but I really don't think anything happens, or it just gets swept under carpet and nothing changes or gets discussed after." Following the inspection, the provided informed us a more robust system had been implemented all incidents were full reported and acted on.

● At the time of the inspection the provider was in the process of developing a duty of candour policy.