Matthew Residential Care Limited

Matthew Residential Care Limited - 59 Woodgrange Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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
Matthew Residential Care Ltd – 59 Woodgrange Avenue is a small care home which is registered to provide care and support to three people with learning disabilities autism or who have complex needs associated with their mental health. At the time of the inspection there were three people 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 the underpinning principles of Right support, right care, right culture.

Right support:
The service did not effectively support people through recognised models of care and treatment for people with a learning disability, autism and behaviours that challenge, such as positive behaviour support approaches (PBS). As a result, whilst we saw features of positive support, including choice, participation, and inclusion, these were not firmly embedded. People did not have maximum choice and control of their lives because the service did not embrace a PBS approach in its entirety.

Right care:
People's behaviour indicated that they found the environment challenging. However, we observed the environment was not fully adapted to match people's needs. Functional assessments had not been carried out to understand the function of people's behaviours. Therefore, without a comprehensive understanding of people's needs, care was not always person-centred.

Right culture:
There were signs that suggested the service was at risk of developing a closed culture. Staff and managers had not received training in managing behaviours that challenge or PBS. There were limited interventions designed to help people cope with challenging environments. The absence of communication plans and strategies to ensure the environment was predictable to people increased people's dependence on staff for their basic needs.

The failure to fully meet the underpinning principles of Right support, right care, right culture, meant we could not be assured that people who used the service were able to live as full a life as possible and achieve

the best possible outcomes.

We made recommendations on the management of people's finances, building people's skill, promoting equal opportunities, and partnership work.

People were not always supported to have maximum choice and control of their lives and staff did not always supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Although people told us they were safe, we were not satisfied the service was set up to respond to their needs appropriately. The service did not support people through recognised models of care and treatment for people with a learning disability or autistic people.

When restrictive practices were used, the service did not have a reporting system in place to ensure reviews were carried out to try and reduce the use of these practices.

The environment was not fully adapted to respond to people's needs. Several environmental factors, including opportunities for meaningful activities had not been adapted to meet people's needs. People did not always take part in activities as planned.

People were not always protected from financial abuse. The service did not demonstrate sound financial management practice. Whilst we did not see evidence of financial dishonesty, people were not supported with their finances in ways that reduced the potential for abuse.

There was lack of input from a multi-disciplinary team to build core skills and competencies, including designing and implementing behavioural support plans. Staff did not have necessary skills and resources to implement behavioural support, even low-level interventions. Managers did not always ensure staff had relevant training, supervision and appraisal.

The governance processes did not help the service to always keep people safe, protect their human rights and provide good care, support and treatment. Whilst there were a range of factors as identified in the report, the lack of resources including specialist input to support a recognised model of care for people with a learning disability who displayed behaviours that challenged was significant.

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 Good (published on 11 April 2019)

Why we inspected
We received concerns in relation to the management of risk, staffing levels, staff training, the management and leadership within the service and people's personal care needs. A decision was made for us to inspect and examine those risks.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the

findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Matthew Residential Care Ltd – 59 Woodgrange Avenue on our website at www.cqc.org.uk.

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 regulation in relation to safe care and treatment, safeguarding people from abuse, staffing, consent, dignity and respect, person centred care and governance. Please see the action we have told the provider to take at the end of this report.

At the time of the inspection the service had enlisted input from a consultancy company, and we saw that an improvement plan had been developed, which broadly mapped ways to address identified risks. On the second day of the inspection, there was evidence improvement work had commenced.

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 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led..

Details are in our responsive findings below.

Matthew Residential Care Limited - 59 Woodgrange Avenue

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
The inspection team consisted of one inspector.

Service and service type
Matthew Residential Care Ltd – 59 Woodgrange Avenue 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.

Notice of inspection
We initially carried out an unannounced visit and we returned on 30 November 2021.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service, including notifications we

had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

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.

During the inspection
We spoke with three people living at the service, three members of staff, a social worker, a management consultant tasked with supporting the service to make improvements and the registered manager. We reviewed care records of three people to help us assess and understand how their care needs were being met. We also reviewed records relating to the running of the service. These included staff recruitment and training records, medicine records and records related to the provider's quality assurance systems, including a current service improvement plan.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

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 Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• Risks were not always identified, monitored and where possible, reduced or prevented. For example, support plans of two people referenced mental health and a history of violence and aggression. However, there were no risk assessments that detailed known triggers, early warning signs and de-escalation methods to be used. Therefore, we could not be assured respective individuals would receive timely intervention if their mental health deteriorated.
• Where risks were identified, they lacked in detail. For example, one person had a diagnosis of a mental health need. Even though risks were highlighted, mental health relapse indicators or behavioural changes staff needed to look for were not specified. Therefore, there was a risk staff might miss specific relapse indicators and would not be able to support the person fully or to promptly report relevant concerns to external agencies.
• Behavioural support plans were not in place. Therefore, people were at risk of unwarranted restrictions because staff did not have access to support plans that outlined sensible and safe steps based on least restrictive options.
• The service did not always manage the safety of the living environment through checks and action to minimise risk. For example, checks were not carried out to show if water temperature was maintained within acceptable ranges. This put people at risk from scalding.

The failure to provide safe care and treatment for people who displayed behaviours that challenged, and the failure to provide staff with appropriate strategies to minimise escalation and reduce the risk of harm to the people and others, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they received good care. One person told us, "Staff are supportive. I feel safe."
• On the second day of the inspection we noted the service had an improvement plan, which they were working to implement with support from an external consultancy company.

Using medicines safely
• The service did not have robust PRN (as needed) medicines procedures to ensure people received medicines at the right time to protect their health.
• Even though PRN protocols were in place, these were not person-centred. They did not contain enough information to support staff to administer medicines as intended by the prescriber. For example, whilst information for when to offer the medicine was contained within the protocols, alternative support was not included. PRN protocols must include or reference interventions to use before the actual administration of

PRN medicines.
• PRN medicines administered were not always accurately recorded on the chart with the date and time of administration. In addition, there was no corresponding entry in people's care records describing the reason why the PRN dose was given, the date and time of administration. Therefore, there was a risk of people using medicines more than was therapeutically necessary.
• Staff were not trained to administer medicines that required an inhaler (portable device that delivers medicines to lungs). One person was prescribed two puffs of a specific medicine four times a day. However, a staff member told us they administered three puffs instead of two stating, "at times the medicine does not come out."
• There were no procedures that showed the service was working to achieve STOMP principles. STOMP stands for stopping over-medication of people with a learning disability, autism or both. We noted examples where PRN medicines were administered for anxiety or agitation before other alternative interventions had been tried and found unhelpful. Additionally, where PRN was used, the service did not maintain accurate records about the person's well-being and behaviour, which limited evidence for evaluation of its effectiveness and appropriateness. This rendered people at risk of prolonged use of psychotropic medicines, which can be associated with severe side effects and physical health problems.

Not having a system in place to support safe and proper medicines management was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The incident reporting system was not well equipped to improve people's safety. A review of accident and incident records in the home evidenced they were all linked to behaviours that challenge. However, staff did not record the sequence of events before the incidents. Thus, without the knowledge of the chain of events that led to recorded incidents, the service did not have means of deriving lessons in order to prevent potential incidents.
• The service did not review the use of practices that could be deemed as restrictive, and look for ways to reduce them. The practice of administering psychotropic medicines for the primary purpose of influencing a person's behaviour is considered restrictive. It is of note that all PRN that was recorded as administered was not to treat anxiety or agitation but to control behaviour. Restrictive practices should be used in limited circumstances as a last resort.

The absence of an effective incident reporting system 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.

Systems and processes to safeguard people from the risk of abuse
• People were not always kept safe from avoidable harm because the service did not always understand how to protect them. Notably, the service did not demonstrate sound financial management practice. Whilst we did not see evidence of financial dishonesty, people were not supported with their finances in ways that reduced the potential for abuse. For example, there were no procedures and processes that underpinned the management of people's money, including risk assessments. Transactions were not countersigned by staff and the person using the service or other suitable witnesses, which meant there was no confirmation of the authenticity of all transactions. Whilst audits were carried out, these were not effective because this was not identified.
• The service had safeguarding policies and procedures and staff were aware of this. Staff had received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. They were aware they could contact the local authority safeguarding team and CQC when needed.

We recommend the provider considers current guidance regarding management of people's finances and take action to update their practice accordingly.

Staffing and recruitment
• On the days of the visits there were sufficient numbers of staff to meet the needs of people. However, although there was a full complement of support workers, there was a general shortage of staff because some staff had not been vaccinated against coronavirus (COVID-19).
• The service had recruitment processes in place which supported safe recruitment decisions. This included pre-employment checks to ensure staff were suitable to work with people living at the service.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was admitting people safely to the service.
• 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 was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• 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.

At the time of the inspection the registered manager was not deployed to work for failing to observe the new regulations making vaccination a condition of deployment. Following the inspection, the registered manager confirmed she had returned to work and all staff had been vaccinated. During the inspection we observed there were COVID-19 risk assessments in place. Whilst policies required to be constantly updated, we saw documentation that showed risk assessments had been carried out. Current COVID-19 screening guidance included assessment for fever.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Interventions were not delivered in a person-centred way and within a PBS (Positive Behaviour Support) framework. A PBS is 'a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge. An essential part of a PBS approach is an understanding of why the behaviour that challenge is displayed. This is achieved by carrying out functional assessments, but these had not been completed for people who needed them. Therefore, with limited understanding of why people behaved as they did, the service was limited in its attempt to reduce or remove the causes of distress for people.
• Equally, least restrictive strategies in relation to reducing behaviours that challenged were partially adopted. For example, we did not observe people engaged in meaningful activities. Equally, least restrictive strategies in relation to reducing behaviours that challenged were partially adopted. For example, we did not observe people engaged in meaningful activities. Creating opportunities for meaningful activities could help reduce boredom . Instead, we noted from records, staff made use of PRN medicines before least restrictive interventions were tried.
• People's support plans did not contain appropriate guidance, in line with best practice, to support people with their behaviour. Support plans of two people referenced risk of physical aggression to others but did not specify details of the aggression nor did they provide staff with sufficient guidance, in line with published best practice, such as the National Institute for Clinical Excellence's "Violence ".

The failure to carry out an assessment of needs for people 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
• Whilst staff had completed mandatory training, they had not received essential training to enable them to carry out their duties effectively, including supporting people with their behaviour and application of PBS. We noted from training records and speaking with staff and managers that they did not have the knowledge required to create suitable environments, develop and implement behavioural support plans.
• Staff responded positively to our questions, indicating they felt valued and had effective line management. However, schedules and records reviewed during the inspection, showed staff appraisals and supervision were not regularly provided.

The failure to provide adequate support and training to staff in order to meet people's needs was a breach

of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment 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).

• The service did not clearly record assessments and any best interest decisions for people identified as lacking mental capacity for certain decisions. For example, staff regularly assisted a person to withdraw their money by a keyworker, however, the support arrangements were not clear and accountable. There was no mental capacity assessment carried out to ensure this arrangement was in the person's best interest.
• Where required, staff had referred people to the local authority for DoLS authorisation. However, a review of records also confirmed interventions were not always delivered in the least restrictive manner. For example, PRN medicines were administered even though there was no record of least restrictive alternatives having been tried to prevent escalation of behaviour.
• A discussion with a social worker confirmed they were looking for an alternative accommodation for one person, who was currently restricted but was ready for independent living. In the meantime, the service was tasked with implementing a plan to teach the person independent living skills. However, there was no coherent plan in place, which may have resulted in delays of the person gaining relevant skills. A plan that was in place to teach the person new skills was not being implemented. Therefore, this person was at risk of prolonged restrictive interventions than they needed.

Failure to ensure people were supported in line with the principles of The MCA, was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• A review of care records confirmed referrals to other healthcare professionals, including input from a psychiatrist, dentist, GP and other allied healthcare professionals. However, behavioural specialist input was limited.
• People's files did not contain health action plans (HAP) and records of annual health checks. A HAP is part of a person-centred planning. It is a record of a person's health and provide information about what that person needs and wants to do to stay healthy.
• Each person was registered with a GP, but the service did not support people to receive a routine annual health check. Annual health checks provide an important means for routinely checking the general health status of adults with learning disabilities.
• There was a record of visits from the community team, but the contents and outcome of these meetings were not shared with the service. The service did not question why the outcome of these visits we not shared. Therefore, there was a risk of gaps in the care of people because staff from different disciplines did not fully work together as a team.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff supported people to have a balanced diet. They told us people chose their meals and if they didn't want the meal on offer an alternative meal was provided.
• People were involved in choosing their food, shopping, and planning their meals. One person told us, "Staff help me with my shopping and cooking."

Adapting service, design, decoration to meet people's needs
• The service did not focus on other wider proactive approaches to develop environment so that it was supportive to people's needs (capable environments).
• Capable environments are those that provide the best setting to support positive interactions and opportunities. Features include, meaningful activities, development of independent skills, predictable environments, provision of real choice, and maintaining a skilled staff team. These features were partially implemented, which meant the service could not respond to people's needs effectively. For example, whilst there were plans to develop independent living skills, these were not being followed.

The failure to carry out an assessment of the needs for people and creating matching environments was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• People personalised their rooms and were included in decisions relating to the interior decoration and design of their home. Their bedrooms were individualised, with their own items such as ornaments and pictures.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• Our discussions and observations of practice demonstrated people did not participate in activities as fully as they could. For example, scheduled activities did not always take place, with staff pointing to weather as a constant reason for not supporting people to go out even though people wanted to go out.
• Appropriate assessments had not been carried out to build appropriate skills required to encourage independence. People receiving care did not engage in meaningful activities. The staff explained to us that people were unwilling. However, there could have been many reasons for people's unwillingness to participate. We established form speaking with staff this had not been explored.

We recommend the service considers PBS guidance on skills building to enable people to lead a more independent life.

• People confirmed staff were supportive, listened to them and were approachable. The atmosphere in the home was friendly and people were at ease with staff, whom they approached from time to time and were always responded to in calm tones and courteous manner.
• People's privacy was respected. Support plans described how people should be supported so that their privacy and dignity were upheld. Staff could describe how they protected people's privacy and dignity. One person told us, "I am happy here. My privacy and dignity are respected."
• The service recognised people's rights to privacy and confidentiality. Care records were stored securely in locked cabinets in the office.

Supporting people to express their views and be involved in making decisions about their care
• There were limited opportunities for people to express views. The design of service user survey questionnaires did not comply with accessibility regulations. The content was not accessible and inclusive. For example, some people could not read but the questionnaire had not been adapted to meet their needs. We discussed the role of advocates or families to ensure people's needs were clearly communicated.
• The service did not have a key-worker system to allow people to speak confidentially regarding issues which were important to them. As a result, there was no platform for person centred meetings to offer a consistent point of contact for people to express views and be involved.
• We reviewed minutes of "residents' meetings" and found whilst people were repeatedly asked for their views, actions were not followed through.

Ensuring people are well treated and supported; respecting equality and diversity

• Equality and diversity were not always promoted. Notably, access to mainstream services including education, training and employment was not actively promoted. As a result, people were missing out on opportunities to develop skills to improve their quality of life.
• Whilst support plans identified potential equality issues, including communication, this was not addressed effectively. For example, support plans of two people identified they could not read or write but communication formats were not adapted to help respective individuals to participate in decisions as much as possible.
• The provider had completed hospital passports. Hospital passports assist people with learning disabilities to provide hospital staff with important information about them when they are admitted to hospital. However, the passports did not contain sufficient information to help hospital staff plan or make necessary reasonable adjustments where this was required. For example, support needs were not clearly identified.
• People felt the quality and variety of the food was satisfactory, but we did not see a variety of food or cultural approaches to mealtimes and eating. Support plans did not record people's food preferences nor did daily notes recorded a range of food.

We recommend the provider considers current guidance on equal opportunities and take action to update their practice accordingly.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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

• Each person receiving care did not have an effective person-centred plan, which meant their needs were not always met. Whilst it was positive that people were supported to make relatively routine choices such as choosing meals and clothing, the service did not create opportunities for major informed choices, including meaningful activities, housing, education, advocacy, and specialist behavioural input. All three support plans contained a section on choice but did not identify people's choices.

• Our observations showed people were not provided with a wide range of activities to choose from. Daily notes of one person recorded the same activities, "watching TV and writing spellings in the dining room". In another example, an individual had been supported to develop a community-based activity program. However, the scheduled activities were inconsistently facilitated. The person in charge could not offer an explanation except that the program was stopped.

• People's needs were not always kept under constant review or revised at any time when these needs changed. The impact of interventions in terms of relevant outcomes were not evaluated. The support plans of two people showed a range of steps to manage their behaviours, however, these were not evaluated so they could be changed or adjusted depending on their impact. Furthermore, support plans were not always adjusted based on professional input. In one example, a psychiatric assessment had noted a deterioration in the behaviour of one person and possible triggers, but the support plan was not adjusted.

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.

• The service did not always ensure people had access to information in formats they could understand. Support plans had a section that covered people's communication. However, there was no individualised plan to support people's understanding. For example, it was highlighted two people could not read or write, but there was no support plan regarding this.

• There were no tailored visual schedules to support people's understanding. For example, one person required routines to be maintained daily, and would have benefitted from visual timetables, which would have helped to inform what was likely to happen during the day and who would be supporting them.

The failure to ensure people received care and support in line with their needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

• We were told no complaints had been received in the last 12 months. The service had a complaints policy and procedure. People spoken with told us they were aware they could speak with staff or the manager if they had any concerns.

End of life care and support

• The service was not providing end of life care. Support plans did not cover end of life care. The registered manager explained that she would ensure that all staff received relevant training and support that they needed to provide people with support if the need arose.

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.

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 did not have processes in place in order to provide behavioural support interventions. All three people required on-going assessments, monitoring and evaluation of their behaviours. However, this was not routinely taking place.

• There were not sufficient resources and infrastructure nor was there a strategic plan to secure the resources necessary to support a recognised model of care for people with a learning disability who displayed behaviours that challenged. We reviewed records of three people and there was no ongoing input from behavioural specialists. As a result, there was no objective means of assessments that provided a clear view of people's needs.

• Managers had not received recent training in behavioural support. Therefore, they were not in a position to create the necessary infrastructure, including policies and procedures that reflected best practice necessary for the delivery of behavioural interventions. As noted earlier, support plans recommended activity schedules, visual timetables, skill acquisition, among others, but these interventions were not implemented effectively.

• There were attempts to involve and engage with people, via surveys, activities and meetings. However, we found these efforts not to be empowering and meaningful because they were not implemented within the context of PBS and related values such as choice and inclusion.

• Discussions with staff and a review of documents showed people's involvement as a formality than something that was firmly embedded. For example, a 2020 survey concluded many people were not involved in the planning and reviewing of their care. However, this had not brought about change, meaning we could not link participation to any outcomes. This was also true of service user meetings, which were limited in scope and without follow up action.

• Moreover, as noted earlier, other factors, which hindered meaningful participation, including accessible information were not fully considered. The provider's survey questionnaire was not presented in a variety of ways, suitable to the needs of people receiving care. Therefore, we could not be assured people were empowered to participate effectively.

• All this meant the service was at risk of creating a closed culture. This is a poor culture that can lead to harm, including human rights breaches such as abuse. The absence of individualised behavioural plans, reasonable adjustments and means to facilitate people's participation meant people were not being fully supported in accordance with The Regulations and Right support, right care, right culture, which is a statutory guidance issued by CQC. We expect providers of learning disabilities services to have regard to

this, in order to maximise choice, control and independence of people using their services.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• There were no effective quality assurance procedures to ensure the registered manager had a clear overview of the service performance. Whilst some environmental audits had been partially completed, there were no effective systems or procedures designed to evaluate the effectiveness of interventions. People's support plans identified a range of outcome measures, which were not evaluated to identify factors that facilitated or hindered progress to achieving them. Therefore, there were no means to check if interventions were having the desired effect or continue to be acceptable to the respective people.
• Care records were not always completed to a very good standard, up to date, and contemporaneous. Files reviewed were disorganised with some documents missing or not easily accessible. A support plan for one person referenced recurrent depression but there was no care plan relating to this. Equally, a medical plan for another person had not been updated since 2019. We could not be assured of actions, steps taken and whether information was sufficiently shared with other professionals to support continuity of care.
• The incident reporting system was not well set up to make sure lessons were learned from previous incidents so that identical or similar accidents could be prevented. The analysis of incidents did not consider effectiveness of current behavioural interventions. Hence it was important the service followed a positive behaviour model of support, because incidents must be analysed in the context of the strategies that are aimed to minimise their occurrence in the first place.

The provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
• The service did not have an established and effective partnership with a multi-disciplinary team to secure specialist input for people who displayed behaviours that challenged. Support plans showed assessments and interventions were not multi-disciplinary. Functional assessments had not been carried out for those who needed them. All in all, there were no quality standards that were being adhered to for the purposes of ensuring every person who displayed behaviours that challenged had a behavioural support plan, that was implemented and audited regularly to ensure action was taken to address gaps.
• Senior managers did not have necessary skills and resources to implement behavioural support, even low-level interventions without specialist input. As already mentioned, they had not completed specific training in behavioural interventions. Hence, it was important the service facilitated a working mechanism with the multi-disciplinary team to design and implement behavioural support plans.

We recommend the service considers relevant guidance to establish and maintain good working relationships with all support services to ensure multi-disciplinary team work is effective.

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 registered manager and provider understood their responsibilities in relation to duty of candour. Duty of candour requires that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment

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 provider was failing to ensure people received care and support in line with their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was failing to ensure people were supported in line with the principles of The Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was failing to provide adequate support and training to staff in order to meet people's needs.