Parkhill Support Services Ltd

# Parkhill Support Services Brighton Road

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Parkhill Support Services Brighton Road provides personal care for people who live in supported living accommodation. The people who use the service have a range of needs including people with a learning disability and autistic people with some people requiring 24-hour support. At the time of our inspection eight people were using the service living in two separate supported living settings. People rented their room from a private landlord and used shared facilities such as kitchens, living rooms and bathrooms. Four rooms at the Brighton Road address had on-suite facilities.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Systems in place did not always protected people from abuse. When people raised concerns, they were not always acted on. People and staff did not always feel safe. Although staff told us they knew how to protect people from harm, they wanted more training to help them support people and keep them safe. When incidents happened, these were recorded but the provider failed to take action to make things better for people and minimise people's risk. Some restrictive practices were used but current legislation and national guidance had not been followed.

Some people's risk had not been identified or assessments were out of date. Medicines were not always managed safely. Medicine was not stored safely and records were poor. This meant it was hard to tell what medicines people had received. Staff worked excessive hours to try and cover shifts and not all staff had received important training to support them in keeping people safe. The staff we spoke with were knowledgeable about people's needs and told us about the risks people faced. They told us they wanted the best outcomes for people and were working hard to achieve these but needed more support and training from the provider to do this.

People were not always supported to communicate their needs or be involved in how the service was run. When people did raise concerns, we could not see how the provider made sure they were listened to.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of

right support, right care, right culture. The provider had not considered the needs of people using the service and had placed people together inappropriately without consultation or thought of the impact on others using the service. This meant people did not always feel safe living in their home. The environment was not suitable for some people and did not allow for their privacy or dignity to be maintained. The design and accessibility of the building did not promote people's independence. Care and support did not always reflect current evidence based guidance and people's human rights were not always upheld. The provider had not applied to the relevant authority to restrict people's liberty and had failed to notify the CQC when people's liberty had been restricted and guidance was not being followed regarding restraint, seclusion and segregation practices.

During the inspection the provider had started to make some changes to make things better for people and staff. After the inspection the provider sent us an action plan stating how they were intending to make improvements.

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

Rating at last inspection
This service was registered with us on 20/03/20 and this is the first inspection.

Why we inspected
This was the first inspection. This inspection was prompted in part due to concerns received about risks to people's safety. A decision was made for us to inspect and examine those risks.

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

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

The provider has sent us an action plan to explain how they are going to mitigate the risks identified at this inspection.

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 people's safety, people's dignity and respect, person-centred care, protecting people from abuse, how the service is managed, how staff are recruited, trained and supported and a failure to notify the CQC of important events and serious incidents at this inspection.

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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe.
Details are in our safe findings below.

**Inadequate**

**Is the service effective?**

The service was not always effective.
Details are in our effective findings below.

**Requires Improvement**

**Is the service caring?**

The service was not always caring.
Details are in our caring findings below.

**Requires Improvement**

**Is the service responsive?**

The service was not always responsive.
Details are in our responsive findings below.

**Requires Improvement**

**Is the service well-led?**

The service was not well-led.
Details are in our well-led findings below.

**Inadequate**

# Parkhill Support Services Brighton 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.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in two 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service did not have a manager registered with the Care Quality Commission at the time of our inspection, we were informed at our inspection they had left the organisation at the end of June 2021. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send

us. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
During our inspection we observed interactions between people and staff to help us understand their experiences of receiving care and support at the service. We spoke with two people using the service, the regional manager, the team leader and five staff members. We looked at records which included care records for three people, three staff files, medicines records and other records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with the local authority to validate documents we had seen on inspection and we made a safeguarding referral to the local safeguarding team.

Inadequate

# Is the service safe?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People and staff told us they did not always feel safe. People were at risk of harm from the actions of another person using the service and staff did not always have the knowledge and skills to protect themselves and people using the service.
• During our inspection we became aware that some restraint and restrictive practices had been in used. However, these were not recorded appropriately and the provider had failed to ensure current legislation and guidance was adhered to.
• Staff had received basic training in safeguarding. However, two staff we spoke with were not sure about the types of abuse that should be reported.
• When staff raised concerns to the registered manager these were not acted on appropriately. Where there was suspected, alleged or actual abuse this was not reported to the relevant authorities.
• We referred our concerns to the local safeguarding authority.

The issues above were a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• The provider did not always assess, monitor and review risks to people's safety. Staff told us about the risks people faced. However, we found not all risks has been recorded and plans were not in place to manage risk associated with some people's needs. For example, staff did not have the information they needed when one person's behaviour became physically challenging. Another person needed support with their mobility including the use of specialised equipment. Although staff told us they knew how to support the person there was nothing written in the person's care records to support this. This meant there was a risk that new or inexperienced staff may not have the information they needed to keep the person safe.
• The provider did not always make sure people were safe in the environment they lived in. Before our inspection we received concerns from a relative about the environment and how unsuitable it was for their family member. During the first day of our inspection we found broken windows, loose and insecure handrails, broken garden fencing, broken internal doors and overflowing rubbish bins. On the second day of our inspection the provider had made broken windows safe, had fixed the garden fencing and ordered commercial waste bins for the safe collection of rubbish.
• Safety checks were not always in place, this meant some people may be at risk. Staff carried out some safety checks, such as fridge and freezer temperatures, fire alarm checks and fire drills. However, hot water checks were not being completed because staff felt people were not at risk even though people's care records suggested otherwise. We saw fire extinguishers were kept in the office, which did not meet relevant fire safety guidance, because there was a risk of one person using them to harm others. The regional

manager confirmed the provider was looking at safe ways to attach these around the building so they could be used in the event of a fire.

Using medicines safely

• Medicines were not always stored or managed safely. On the first day of our inspection the door to the medicine room where people's medicines were stored was broken. Only two of the four cabinets inside of the medicine room were in use and could be locked. One person's medicine was being stored in a locked metal box that could easily be removed from the room. Unused medicines were easily accessible to people and had not been locked away.

• When we looked at people's medicine administration records (MARs) we found examples where records had not been fully completed. Records did not always show if people had received their medicines or the reasons why people did not take their medicines.

• People's PRN or 'as required' medicine was not always recorded and there was no guidance in place to help staff know when and how PRN should be given, the signs to look out for and when to offer the medicine. This includes verbal and non-verbal cues, the dosage and if there were any less restrictive alternatives to PRN.

• There were no systems in place to audit people's medicines or make sure people had the right amount of medicine. When people had boxed medicine there were no checks in place to make sure the correct amount of medicine had been given or how much medicine was left in the box. Staff had been giving one person medicine from an old blister pack as the pharmacy had failed to deliver new supplies. This meant the person may have been taking the wrong medicine. There was no system in place to make sure people had enough medicine and received their medicine when they needed it. After the inspection the provider sent us details of a new medicine audit they had put in place.

• Staff did not always receive the training and support they needed to administer people's medicines. On the first day of our inspection five staff had not completed the providers on-line training in medicine management. There were no competency checks in place so we could not be sure how the provider made sure staff had the knowledge and skills they needed to give people their medicines in a safe way.

Learning lessons when things go wrong

• The provider did not always take action when things went wrong, this meant people were at an increased risk of harm. Staff recorded incidents involving people who used the service. Although incidents were reported to senior management on a regular basis there was no evidence of the provider taking action to improve safety for people and staff. The regional manager sent us information after our inspection about the systems in place to regularly review the incidents reported. However, there was no information to suggest any learning had taken place and staff had received the support they needed.

The issues above were a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Staffing and recruitment

• The service did not always have enough staff to keep people safe. During our inspection four staff were on duty during the day with two staff on waking night shifts. One person needed two staff to support them during their waking hours and other people required staff support throughout the day with personal care needs. Staff told us sometimes there were only three staff members on duty and this meant other people did not receive the support they needed.

• One person told us, they needed two staff to support them at night. Staff often rushed with the person's care needs because they were worried about people's safety in the rest of the house if another person's behaviour escalated without staff support.

• Staff worked excessive hours to cover shifts. Agency staff were not used and when shifts needed to be

covered staff worked for 24 hours without an adequate break putting themselves and people at risk.

The issues above were a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities)

• The provider did not always make sure recruitment records were complete. There was a risk staff may not always be suitable for their role.
• The provider had computerised systems in place to make sure the right checks for staff recruitment had been completed. We looked at this system with the regional manager and found important documentation was missing such as risk assessments, application forms, references and criminal record checks. Although the system checklist said they had been completed, we were unable to verify these documents so we could not be sure all staff had been recruited safely.
• After the inspection we received confirmation from the provider that records were stored in various places on the system and the regional manager had not known where to access these documents. We were concerned because the systems did not allow access to important recruitment information to ensure the provider met this regulation and recruitment was safe.

The issues above were a breach of Regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities)

Preventing and controlling infection
• Checks were in place to prevent visitors from catching and spreading infections.
• Staff told us they would normally wear PPE when they were cleaning, preparing food or supporting people with personal care. People and staff were not wearing PPE in communal areas. However, staff remained socially distanced from people. Staff told us this was an informed choice but we did not see any evidence of consultation with people at the service or risk assessments in place to protect vulnerable people from COVID-19.
• Staff and people were undertaking regular tests and some staff and people had received the COVID-19 vaccine.
• The provider had an infection control policy and protocols in place should people or staff test positive for the COVID-19 virus.
• The providers had a risk assessment in place for staff at risk of COVID-19. However, we did not see any completed assessments in staff records.
• The provider had not been completing important information required by the CQC to enable us to monitor COVID-19 outbreaks, the testing program and vaccinations.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Staff were not always supported or trained to carry out their role. Staff supervision was inconsistent and records indicated only three staff members had received a supervision meeting with their manager.
• Staff told us they had received training as part of their induction but would like more training to help them keep people safe and protect themselves when one person's behaviour challenged the service.
• The provider had systems in place to monitor staff training but some staff had not received training such as medicine administration. Two staff members had competed one of the 21 training courses provided and this meant training such as safeguarding, manual handling, fire safety and infection control had not been completed. After the inspection the provider informed us that staff had received training and some staff may have required refresher training.
• Although we were assured by the team leader that new staff members worked with more experienced staff to offer support, the provider had not completed any competency checks , monitored supervision and had not provided adequate training. This meant staff may not have the knowledge and skills they needed to carry out their duties.

This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• Systems were not in place to record and monitor people's healthcare. This meant people were at risk of not receiving the healthcare they needed. Staff told us they worked with healthcare professionals so people could access the support they needed. However, visits with healthcare professionals were not always recorded in people's care records and it was hard to see how actions and recommendations from healthcare professionals were recorded and acted upon.
• Staff told us they had a system for recording healthcare appointments so they were able to remind people and support them to appointments if required. However, without systems in place to monitor and record people's ongoing healthcare needs, the provider may not be able to monitor people's progress or act accordingly when improvements in people's health were not seen.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care and support did not always reflect current evidence-based guidance, standards and best practice. People's needs were assessed when they first started to use the service. However, we were concerned that the assessment process did not consider the support needs of other people living at the service and how the

impact of other people's behaviour may affect them. It was not clear how people had been involved in decision's about new tenants joining them.
• We had identified people had not always received care in line with national guidance and standards regarding the use of restraint. Although the provider sent us a positive behaviour support plan developed to guide staff in understanding the behaviour of one person this was not accessible or available to staff. This meant staff did not always have the reactive strategies they needed to prevent or reduce behaviour that challenges.

This was a breach of Regulation 17 (Good Governance) 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.
• People's rights were not always upheld. Although people's mental capacity had been assessed, these assessments were not always completed when people first joined the service. The provider did not always understand or work within the requirements of the MCA or associated guidance. The provider had delayed sending an application to deprive one person of their liberty and sent this to the wrong authority causing a delay in the assessment. This meant unlawful restraint, seclusion and segregation practices were being used.

The issues above were a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us some people lacked the capacity to make decisions about their care and support. Most staff had received training in MCA and told us they always offered people choice.

Adapting service, design, decoration to meet people's needs
• This was a supported living service. This meant the landlord of the property was responsible for repairs. However, the provider had a responsibility to keep people safe. On the first day of our inspection we found the property needed urgent maintenance and there were issues in communal areas that made the property unsafe for people living there. This included loose handrails, broken doors and windows and broken garden fencing.
• On the second day of the inspection the regional manager explained the landlord had failed to maintain the upkeep of the property so the provider had started to make essential repairs. Cracked glass had been covered, fences fixed and locks had been placed on the medicine room door.

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

• Staff told us they would speak to people about their food choices and would support people to buy their shopping if this was needed. People had their own cupboards in the kitchen to store food and some people kept food and a fridge in their room.

• Staff told us they supported people to be as independent as they could be with food preparation but would prepare meals for people if this is what they wanted.

• Two people were unable to access the kitchen because this room was not easily accessible to them due to a damaged door. This meant so were unable to prepare and cook meals for themselves. Although, they told us they enjoyed the food staff prepared for them we were concerned about the lack of independence in a supported living environment. We made the provider aware of the maintenance issues at the service. After the inspection the provider informed us the door had been fixed and people were now able to access the kitchen.

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.

This is the first inspection for this newly registered service. This key question has been rated 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
• The provider did not always maximise people's choice, control and independence. People told us staff treated them as individuals and spoke to them with dignity and respect. Staff and people gave examples of how staff respected people's privacy when supporting them.
• However, the environment had a detrimental impact on people's dignity and independence. The provider had failed to make the reasonable adjustments necessary to maximise people's independence, and the building had not been adapted and improved to allow people with restricted mobility to access all areas of the home. For example, the kitchen was not accessible for two people and this meant they were reliant of staff to prepare and cook meals and not everyone at the service was able to access washing facilities. The regional manager explained there had been a delay with proposed building work for one person's assisted bathroom, partly due to COVID-19 restrictions.

This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities)

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they liked the staff at the service and felt they tried their best in difficult circumstances. One person told us staff would always support them at home and in the community if they asked for help but felt staff were busy trying to keep themselves and people living at the service safe.
• Staff spoke about people in a kind and caring way. One staff member told us, "We genuinely care and it makes a difference to people". We observed caring and supportive conversations between staff and people throughout our inspection.
• Staff knew people well and told us about peoples likes and dislikes and how they supported people. For example, people's favourite foods, where they liked to go and visits to families and friends. One staff member explained how important it was to try and spend time with people and told us how they would always put people first, before the other household tasks they had to do.

Supporting people to express their views and be involved in making decisions about their care
• People told us although they spoke to staff, they did not feel like they were always listened to. One person told us "They [staff] listen but I'm not sure I get through to them" and another person told us about a delay in the registered manager replacing damaged items.
• People had been asked to complete a survey in June 2021. We saw the results from two surveys and both had negative comments about the service. However, when we asked the regional manager if any actions

had been taken as a result of the surveys, they were unable to tell us.
• People were not always able to express their views. One person told us, "We used to have residents' meetings. They [staff] would say [person's name] we are having a house meeting and we would talk about things, what's happening, what's bothering us, we haven't had that for ages. Sometimes I hear them talking I ask if they are having a house meeting, they say they are not having a house meeting. I'm not involved in anything here now." Staff told us they no longer held house meetings, mainly due to the COVID-19 pandemic. They told us they spoke to people individually although this was not written down so we could not evidence people's involvement.

Requires Improvement

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

• Information about people was not always available to staff. Staff used a computer based application on a hand-held device to record daily notes and the care and support people received. However, detailed information about people's care was not available on the device. Staff knew people well and told us about people's likes and dislikes, favourite food and activities but we were concerned new or less experienced staff may not have the information they needed to meet people's needs.

• The provider was in transition of moving from paper care records to a computer based system. It was not clear on our first day of inspection if staff referred to computerised records or paper records. However, we were later told the computer had been broken for some time. When we checked the providers records these indicated the computer monitor had been broken since 18 May 2021. Staff were reliant on paper based records if they wished to access people's care plans and risk assessments. Some information was not stored on paper records and this meant important information about people's care was not always available to staff. The provider replaced the broken monitor after the first day of our inspection.

• It was not clear how people were involved in their care and support plans or how they would have access to them. Staff told us conversations with people were informal. There were no meetings or keyworker sessions with people and there was no evidence to indicate people had been involved in their ongoing care and support.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• Staff told us they encouraged people to keep contact with their friends and relatives and gave examples of how contact was maintained throughout the COVID-19 pandemic.

• People living at the service had a wide range of needs, with some people being more independent than others. People who were more independent were supported by staff to access the community. However, the range of activities available to people who were less independent was very limited. Staff told us one person did not like to leave their room when another person using the service was awake. Another person could only watch television in the lounge because the television in their room had been broken and not yet replaced. Staff told us it had been difficult to support people with their activities during the COVID-19 lockdown and they had seen one person's behaviour escalate as a result. Staff were looking forward to restrictions easing to help support people to follow their interests and hobbies. After the inspection the provider told us the person's television in their room had been replaced. This meant the person was able to choose where they watched television and when.

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.
• Some information was available for people in an easy read and pictorial format such as surveys seeking people's views and 'all about me' communication passports. However, we were concerned that little consideration was given to people's individual communication needs with blanket easy read documents being used when people may benefit from alternative forms of communication. We will look at this again when we next inspect.

End of life care and support
• No one using the service was receiving end of life care at the time of our inspection. People had end of life care plans in their files but these had not been completed.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities)

Improving care quality in response to complaints or concerns
• The provider had systems in place to monitor and respond to complaints.
• Information was available to people on how to make a complaint if they were unhappy or wanted to make a complaint. Posters were displayed in communal areas around the service and information was contained in people's care records.
• People told us they would speak to staff if they needed to and felt staff would do what they could.
• There were no recorded complaints at the service at the time of our inspection.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

• The registered manager was not available at the time of our inspection. The regional manager confirmed the registered manger had left the organisation at the end of June 2021. We were informed another manager had been recruited although they had not started work at the time of our inspection. After our inspection the provider informed us the new manager had now started working at the service.

• Staff told us they did not know where the registered manager was and said the registered manager was rarely at the service. There appeared to be little support for staff and when staff asked for help this had not been acted upon. This did not give us assurance that the service had been effectively managed and overseen by the registered manager.

• Although the provider assured us they had quality assurance audits in place, these had been conducted remotely during the COVID-19 pandemic and had failed to identify the issues we found during this inspection that had impacted on people's safety.

• Some audits and safety checks had been carried out and were up to date, for example, the fire checks and audits were complete and fridge and freezer temperatures were regularly recorded. However, throughout our inspection we found issues with the quality or availability of records within the service that had an impact on the quality of care people received.

• Medicine records were poor and we were unable to find evidence that audits had been carried out. People's care records were not always complete and people's risk had not always been identified and recorded.

• Staff training was incomplete and staff were working without having received the training identified as mandatory by the provider.

• The provider had failed to understand its responsibilities in line with requirements of the providers registration and had not notified the CQC of certain changes, events and incidents. This meant the CQC was unaware of the risks people were facing and unable to monitor the service and ensure improvements were made.

• The provider had started to address some of the issues and had sent us an action plan detailing the improvements they planned to make. We also saw some immediate improvements had been made to the environment to help keep people safe on the second day of our inspection.

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; continuous learning and improving care

• Although staff had reported incidents to the provider it was hard to see how the provider had used this

information to make improvements to the care people received. The regional manager explained the provider employed a behaviour specialist and a number of staff who were able to train staff in physical intervention. We saw the feedback provided by the behaviour specialist to the provider on the incidents that had occurred. However, we could not see how this was communicated to staff or how the feedback given would be useful to staff who were trying to manage people's behaviour daily.
• The provider had failed to follow best practice guidance in place concerning restraint, restriction and exclusion. Staff and people did not receive the support they needed when things went wrong and this had impacted on people's care and resulted in the risk of harm or actual harm.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• The provider had not always notified the CQC of incidents. For example, the provider had not notified us of incidents when there was alleged or actual abuse to people, serious injuries and when there had been Police involvement. This meant people were at increased risk because notification of these events helps us monitor the safety and quality of care and share information with other authorities when appropriate.

This was a breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Staff told us they worked well together as a team and supported each other to provide care and support to the people using the service. However, they did not have a say in how the service was run and did not feel confident raising concerns. They told us any issues raised would not always be taken seriously. During our inspection the regional manager spoke to staff and encouraged them to speak up. They assured us they would listen and make changes based on the concerns staff had raised.
• The mix of people using the service had not always been considered, with some people being placed together inappropriately in a way that compromised their safety and wellbeing. This had a negative effect on the culture of the service and impacted on the time available for staff to engage with people.
• People were not always involved in the running of the service. We were unable to find evidence of how people were able to raise concerns or if they did, what action was taken.

Working in partnership with others
• Staff told us they worked with healthcare professionals. However, there was limited evidence of engagement in people's files.

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 |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider did not always make sure people received the care and support that was personalised specifically for them. The provider did not always involve people in making decisions about their care and treatment and support them to do this.<br>Regulation 9 (1)(3)(b)(c)(d)(e)(f) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider did not always support people to maximise their independence.<br>Regulation 10 (2)(b) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider systems were not always adequate to ensure decisions made in respect of an applicant's character were recorded and risk assessed.<br>Regulation 19(1)(a) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not always ensure sufficient numbers of staff were deployed to meet people's needs. Staff did not receive the |

appropriate training and support to carry out the duties they were employed to perform. Regulation 18 (1)(2)(a)