People in Action

People in Action - 132 Manor Court Road

Inspection report

132-134 Manor Court Road
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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?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
132-134 Manor Court Road is a care home providing accommodation with personal care for up to 8 people. The home is purpose-built accommodation, providing care and support to people across 2 floors. At the time of our inspection visit there were 7 people living at the home.

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.

People's experience of using this service and what we found
People did not always receive person centred care in line with Right, Care, Right Support, Right Culture.

Right Support: People had limited opportunities to leave the service and pursue social interests within their local community. There was limited guidance to inform staff how to enrich people's lives through positive engagement and meaningful activities. People's goals and aspirations were not always identified with people or those involved in their care. Risks associated with people's health and wellbeing were not always managed safely. Where risks had been identified, some records contained conflicting information about how staff should manage these risks.

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

Right Care: People were not always involved in making decisions about their care. There was limited consideration given to the varying ways people could be empowered to make everyday choices using different communication methods.

Right Culture: The service did not always have a person-centred culture which empowered people to achieve their goals and aspirations. Systems were not operated effectively to identify if people were receiving person centred care in line with Right Care, Right Support, Right Culture.

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 March 2018). The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk at the service and the governance of the service. This inspection examined 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.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, person centred care, staffing levels and good governance at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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?

Inadequate

The service was not 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 well led findings below.

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Detailed findings

Background to this inspection

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

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
132-134 Manor Road a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. 132-134 Manor Court Road is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
The inspection was unannounced. Inspection activity started on 23 February 2023 and ended on 6 March 2023. We visited the location's service on 23 February 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We looked at the information we had received from relatives and people who used the service. We asked the local authority for any information they had which would aid our inspection. Local authorities, together with other agencies may have responsibility for funding people who use the service and monitoring its quality. The provider had been asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people's relatives about their experience of the care provided and contacted 1 person's advocate. We continued to speak with the local authority commissioning team. We received feedback from a visiting health professional. We carried out observations on both floors of the home to assess people's experiences of living there. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We contacted and received feedback from 9 members of staff including the provider's representative, the registered manager, the assistant manager, a maintenance and facilities manager.

We reviewed a range of records. This included 3 people's care records and/or medication records. A variety of documents relating to the management of the service, including policies, training records, maintenance records, 2 recruitment files and quality assurance documents.

After the inspection we continued to receive information from the provider and registered manager regarding the governance of the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Risks to people's health and safety were not always assessed and care plans lacked guidance and clarity for staff on how to manage the risks. For example, some people in the home had a catheter but risk assessment and care plans were not always in place or lacked the required detail to instruct staff on how they should mitigate those risks and care for people safely.
- Staff lacked knowledge of the signs and symptoms that may indicate underlying complications with catheters. For example, staff did not understand that catheter bags needed to be positioned on catheter stands and placed below the level of the person's bladder to ensure the catheter flowed correctly. One person was in bed during the day and did not have their catheter bag on a stand which put them at increased risk of infection.
- Risk management plans contained conflicting information about how to protect people from the risk of choking and staff and managers told us different information on how they should mitigate this risk. For example, there was confusion about how to safely support the person with their risk of choking. 1 person's care records guided staff to use 1 scoop of thickener which is added to ingestible liquids to thicken them, in their liquid medicine and 3 scoops of thickener in fluids, yet the manager told us this person had been officially assessed as needing 2 scoops of thickener. Staff told us this person needed 2 scoops of thickener. The person was placed at an increased risk of choking, if the wrong amount of thickener was used.
- Risks related to the safe storage of thickener had not been assessed. Thickener was stored on kitchen worktops in people's reach. People lacked the capacity to understand the risks involved if they incorrectly ingested the thickener. Thickener has been the subject of safety alerts due to the risk of choking if ingested incorrectly. The registered manager was unaware of those risks.
- People did not have effective risk management plans to manage skin integrity and developing damage to their skin. One person's care record stated they had developed wounds in December 2022. The registered manager told us these had healed, however, staff told us the person still had wounds. Records did not state the wounds had healed. District nurses gave specific guidance to manage these wounds which included regular pressure relief every 3 hours, such as turning the person in bed. There were no records to evidence this guidance was being followed. Staff were not provided with this information to regularly turn the person to prevent their skin from deteriorating further. Staff were also not provided with information on how to correctly set their mattress, to help relieve pressure to their skin.
- People did not have effective risk management plans to manage the risks associated with epilepsy. Risk management plans did not always contain information on the different types of epilepsy, the risks of a seizure, and preventative actions that could be taken to reduce the risks of seizures occurring. One person's care record stated they had not experienced a seizure since 2021, yet their daily records stated they had a seizure lasting 7 minutes in August 2022. Their epilepsy care plan was inconsistent in the information it provided to staff about who they should contact in the event of a seizure.

Using medicines safely

● People did not always receive their medicines as prescribed. Medicine administration records (MAR) did not always show people had received their prescribed medicines.

● Some people needed medicines on an 'as required' (PRN) basis. There were not always guidelines for staff to follow to determine when or how these medicines should be given to people safely. For example, when people should be offered pain relief.

● Medicine administration records (MAR) were not always clear or legible and did not follow best practice guidance. For example, Protocols did not describe how much thickener should be used to ensure liquid medicines were safe to give to people at risk of choking.

● Due to poor recording, it was not always clear the dates of when people received their medicines. For example, cycle dates written at the top of people's MAR did not match the dates of administration.

● Some medicines prescribed on an PRN basis, were added to the same MAR as regular prescribed medicines. This meant staff had conflicting guidance about the dose of medicine people could be given. This placed people at risk of not receiving their medicines as prescribed.

Preventing and controlling infection

● We were not assured infection prevention and control practices within the home were always safe and protected people from the risk of infection.

● Staff were observed to wear their Personal Protective Equipment (PPE) incorrectly. When staff wore face masks they were often pulled below their nose or chin. One staff member was seen with their face mask hooked on their sleeve. PPE was not always removed after providing care to people which posed a risk of cross contamination.

● A person was seen moving around on the floor using their hands. Staff made no attempt to help this person wash their hands before eating their meal.

● Crash mats, positioned to cushion people if they fell, were visibly dirty and some furniture was chipped which meant it could not be cleaned properly. In one person's bedroom, the surface around their sink was chipped and damaged which meant it could not be cleaned properly.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

Visiting in care homes

● On the first day of our inspection visit there were some restrictions on visiting the home on display at the location. The registered manager explained that this was not correct, as there was not an outbreak of COVID-19 at the service. Following our inspection visit we were assured that the visiting policy for the home updated showing there were no restrictions in place around visiting, in accordance with government guidance.

Staffing and recruitment

● Staff told us they did not always have the knowledge, skills and training they required to complete their roles effectively or safely. For example, the service was registered to support people with learning disabilities and autistic spectrum disorder. Staff had not received up to date training in how to support people with these needs. Staff had also not received regular training in how to support people with their health conditions such as catheter care and diabetes.

● People's relatives told us they did not always feel there were enough staff at the service to meet people's needs. One relative said that due to a lack of staff their family member was not able to go out as much as they wished. They commented, "It's definitely a staffing issue. [Person's name] sleeps a lot, maybe it's

boredom."
● We received feedback from staff that due to some people's higher dependency needs, they were prevented from supporting people to go out in the local community. The registered manager confirmed staff did not have time allocated to them, to support people with going out and individual activities. A staff member said, "We don't have enough staff to get people out."
● There were enough numbers of care staff to meet people's personal care needs at the service on the day of our inspection visit. However, the registered manager and staff confirmed the service relied on agency staff during staff shortages. Some staff told us that the skills of agency staff was variable.
Systems to monitor there were enough staff, who were skilled and competent to fulfil their roles, were not effective. This was a breach of regulation 18 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing.

● The registered provider undertook background checks of potential staff to assure themselves of the suitability of new permanent staff to work at the home. Pre-employment recruitment checks included reference requests and Disclosure and Barring Service (DBS) checks. This helps employers make safer recruitment decisions so that only suitable people work with those who are vulnerable.

Systems and processes to safeguard people from the risk of abuse
● The registered manager understood their legal responsibilities to protect people and share important information with the local authority and CQC. However, although staff had some training in safeguarding people, they struggled to tell us their understanding of safeguarding or what concerns they would report to be investigated further.
● Information on safeguarding was displayed in corridors throughout the home.

Learning lessons when things go wrong
● Accidents and incidents were not recorded in a log and analysed by the registered manager and the provider after events occurred, to help ensure action was taken to prevent reoccurrence.
● Trends and patterns were not always identified and did not always lead to care records being updated, to help ensure people were protected from avoidable harm.
● Following our inspection visit, the provider acted on our feedback positively. They updated how they monitored blood sugar levels for people with diabetes. Risk assessments and risk management plans were also updated.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments of people's needs had not always identified people's needs had changed over time, and risk assessment and risk management plans did not always reflect people's current support requirements.
- There was no evidence in people's assessment and care records to demonstrate people and their relatives had been involved in assessing their needs and putting their care and support into place. There was limited evidence to show that people received sufficient support to contribute to their assessment or identify their choices.
- Care and support plans did not always include information about what was important to people and document their preferences about how their goals might be achieved.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked with external health professionals in response to people's changing needs. This included district nurses and speech and language therapists. One relative told us, "When [person's name] was quite poorly, the registered manager did push hard to get them the right treatment." However, when guidance was provided, records did not always show health professionals advice had been followed.
- Information sharing to ensure that staff and other professionals had access to up-to-date information about people's needs was ineffective. Records did not always support the effective management of risk.
- Health action plans were not up to date and, in some cases, not completed. For example, one person had a catheter, yet their health action plan stated that there were no known issues with this person's urinary system. These documents are used to share key information about people's needs and should be taken to all appointments and hospital visits. The provider acted to update care records after our inspection visit, including people's health action plans.

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

- Areas of the home were tired and needed redecorating. Skirting boards and door frames were heavily chipped and scuffed. Some furniture was poorly maintained and chipped on the corners.
- There was a lack of pictures or displays within the home to show people were involved in activities outside the home. There was limited information available for people in the home to tell them about local events, activities and outings they might enjoy. An activities plan was not shared with people at the home.
- People's bedrooms were personalised. However, whilst people seemed to know their way around the home, there was a lack of information on display in the home to tell people where each person's bedroom was, and who lived at the home.

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

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

● Records did not always evidence that decisions regarding people's care and treatment had been made in their best interests. One person's care record stated, due to extreme levels of distress when taken to the bathroom, it had been decided to give the person care in their bed rather than using the bathroom. This meant the person was not able to access a shower or bathing facilities. There was no evidence a best interest discussion had taken place to explore whether other strategies could have been the least restrictive option, to support the person with their personal care needs.
● Staff lacked understanding of the importance of promoting choice and control for people who struggled to make decisions on their own. One person's care record stated they should be supported to go on day trips. A member of staff said, "It would be difficult to tell what [person] would want to do if we took [person] out because of their mental capacity. They would probably be happy with anything to be honest."
● The service was working within the principles of the MCA when applying for the appropriate legal authorisations to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staff support: induction, training, skills and experience
● The provider's training matrix showed permanent staff received an induction and training which included the minimum standards of how to deliver safe care and treatment to people. However, staff training was not always kept up to date and did not always include areas where people required support. For example, 2 people had a catheter, but staff did not receive training in catheter care.
● Staff told us they received supervision, and some had received appraisals. Some staff members told us they required more support with identifying their training and development needs.

Supporting people to eat and drink enough to maintain a balanced diet
● When people's nutritional needs changed, they were referred to dieticians and speech and language therapists. Information about specialised diets was included in some care plans.
● Staff were observed to support people to eat and drink when they were identified as needing that support. Some people could eat their meals independently and were encouraged to do so.

Inadequate

Is the service caring?

Our findings

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

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

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

- We were unable to gather feedback from people who lived at the home due to their complex support needs. However, we observed people were not always given dignified care.
- One person chose to move around on the floor and staff made little attempt to communicate with the person. The person was provided with small plastic balls, as an activity to occupy them. The person spent their time on the floor rolling the balls. Staff periodically entered the room and threw the balls back to the person, rather than finding opportunities to engage in meaningful, dignified and caring interactions. Staff said the person enjoyed this activity, but also commented, "[Person's name] is ok, we just make sure they are out of harm's way."
- Staff did not always use opportunities to spend time with people when they could. People spent time alone, in their room, or in separate areas at the home. Staff sat together in separate areas away from people. One person sought the company and interaction of staff and others; they walked around the home and tried to engage in activities or communicate with people and staff.
- Staff did not regularly or routinely check on people when they were alone in their bedrooms, which may have caused people to feel isolated and alone. One person was in their bedroom for the whole day of our inspection visit. Staff made limited attempts to interact with this person, other than to provide their meal.
- Privacy was not always promoted. The locks on some shared bathrooms had been removed and there was no way of knowing whether these bathrooms were in use, or not. Staff told us this was because 1 person sometimes locked themselves in the bathroom. The provider had not sought locking systems that could be opened from the outside in an emergency but had removed all locks. This meant staff, visitors or people who lived at the home, could enter bathrooms when they were in use.
- People's bedrooms and personal spaces were not protected from other people entering them and removing items. One person walked around the home and entered people's bedrooms. One staff member confirmed, "Yes, they can do this. They remove things [personal possessions] from people's bedrooms too."

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

- Records did not always evidence how people were supported to be involved in making decisions about their care. One relative told us, "I'm not really involved in making decisions."
- When changes were made to people's care plans, records did not always demonstrate why those decisions had been made. For example, when 1 person's needs changed and they needed to be supported in their bedroom, records did not evidence who had been consulted about this change or the reasons for it.
- Records did not promote the importance of people's views and involvement in their care as a priority. For

example, care plans included aims for people to promote social interaction and stimulation away from the home, but finances were recorded as needing to be considered first when planning days out, and a lack of planning meant simple cost-effective activities did not occur.

● One person liked to go shopping, a staff member said they had not done this activity since Christmas due to poor staffing levels. Another person was described by staff as enjoying a local Disco on Mondays, but they were not always able to go due to a lack of planning of the rota.

Systems failed to ensure service users were always treated with dignity and respect and protect their privacy. Systems had failed to support the autonomy, independence and involvement in the community of the service user. This was a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

● People were not consistently supported to follow their interests or engage in meaningful activities they enjoyed, to help prevent boredom, isolation and a lack of stimulation. Relative's comments included; "[Person's name] loves going out. They don't go out as often as I would like. It's the eternal staffing problem", "They haven't done much recently. I think activities are going to start again. They are starting to go out now I think?" and "A recent trip they planned to Blackpool didn't happen. They haven't gone on holiday recently."

● There were no activities on the day of our inspection and staff told us that activities did not take place in the home. One staff member said, "We don't do activities here. They've all got things that they like. [Person's name] likes lots of sensory things like their plastic balls - that's what [person] likes, that's their activity."

● Staff could tell us how people liked to spend their time, but we observed no occasions when staff spent time with people doing activities they enjoyed. There were limited interactions between staff and people with no opportunities to meaningfully engage.

● Staff told us that staffing levels prevented them from taking people out and doing things they enjoyed, away from the home. One staff member said, "It's bad on them all not being helped to get out." Another staff member said, "We've tried timetables for people; it never works out. It's staffing. It's just the way things are."

● Staff told us the provider did not arrange for external people to come into the home and organise or support group activities.

● People were not always supported to maintain relationships outside of the home. One relative had not been informed that their family member had been moved downstairs. They said, "The last time I saw [person] was Christmas 2021. I can't get up the stairs, so I don't visit. Sometimes I ring to see how [person] is. They only call me if [person's name] had a fall or gone to hospital."

The provider had failed to ensure people were always treated with dignity and respect, and to protect their privacy. People's autonomy, independence and involvement in the community had not been fully supported. This was a breach of regulation 10 (1), Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Care plans did not always reflect people's needs and preferences. Overall, staff did not know how to support people safely, as care records did not document how safe care should be delivered, in accordance with people's preferences.

● Care records were not always up to date. For example, regular reviews of people's care records did not

take place when their needs changed, which meant records did not show the care and support people required.
● The care provided was not person centred, as it was not based on what was important to people. Conversations with staff and records showed that care was focused on meeting people's physical care needs. One staff member told us that having a good quality of life for people in the home was, "being well medicated and well fed."
●The registered manager told us they were starting to pull together planned activities timetables that met people's individual preferences. However, records did not evidence that planned activities were taking place at the time of our inspection visit.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The service worked with specialists to develop communication plans for some people. For example, one person's communication care plan was developed by speech and language therapists to provide staff with guidance and suggestions on communicating with people who have dementia.
● However, due to a lack of oversight of people's care records, this information was not always easy to find and refer to, so we could not be assured this information had been shared effectively with staff.
● Care plans included some pictures and symbols. However, these were small and difficult to see clearly and did not provide us with assurances that this information was accessible to people.

Improving care quality in response to complaints or concerns
● Relatives told us they knew how to raise a complaint if they needed to. One relative said, "If I have problems, I would bring it up. I complained about something; they [staff] did put it right."
● The provider had a complaints policy and procedure. Copies of the procedure were available, so people knew how to escalate any complaints they had.
● We saw a record of complaints were kept by the management team to analyse any themes or trends.
● In response to our inspection the provider took some action to address our findings and concerns.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Systems and processes to maintain oversight of the quality and safety of care were ineffective. The provider failed to have effective systems in place to manage risks relating to the premises. For example, an effective risk management plan was not in place to monitor and mitigate the risk of people contracting Legionella. The provider had not taken immediate action to mitigate risks around fire safety such as labelling all fire exits. This placed people at increased risk of harm through their environment.
- Governance procedures had failed to identify the concerns we found at our inspection. This included risks in relation to medicines management, and the gaps in risk assessment and risk mitigation plans in regard to people's safety. This meant related action had not been taken to make improvements at the service.
- Governance procedures had failed to identify care records were not always kept up to date and did not reflect people's current support needs. This meant staff did not have all the information they required to ensure people's needs were met.
- The provider and registered manager had failed to identify there were not enough skilled and competent staff employed by the service to meet people's needs. This meant people were not always cared for safely.
- The registered manager did not fully understand regulatory and policy requirements in relation to services that support autistic people and people with learning disabilities. Mandatory training, which is now a legal requirement, had not always been provided to staff. The provider had not ensured staff at the service completed mandatory training requirements. This meant people were not always cared for by staff who understood their support needs.
- The culture at the service was not person centred, as it did not focus on achieving good outcomes for people, and the preferences of people. The culture at the service was task focussed and did not always meet people's social needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was no evidence people were involved in planning their own care. Relatives were not involved in planning people's care.
- People and their relatives were not asked for their feedback on the service and how it met their needs.
- People and relatives were not invited to meetings to discuss their needs and wishes, or complete surveys about the service they received.

Systems to ensure compliance with the regulations, and systems to assess monitor and improve the service were not established and operated effectively. Records were not always complete in respect of person's care. This was a breach of regulation 17 (1)(2), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● Following our inspection visit, the provider and registered manager put in place an action plan to improve their service.

● Relatives told us they knew how to raise any concerns or complaints they had and felt these would be acted on.

Working in partnership with others

● The management team and staff worked with a variety of health care professionals to help improve and meet people's healthcare requirements. However, records did not always show health advice had been followed.

● Following our inspection visit the provider continued to work with local commissioners to effect improvements at the home.

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 management team understood their responsibility under the duty of candour and the requirement to be open and transparent when something goes wrong. Relatives told us they had been informed and kept up to date when incidents or accidents had occurred.

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 10 HSCA RA Regulations 2014 Dignity and respect 10(1) The provider had failed to ensure service users were always treated with dignity and respect. 10(2)(a) The provider had failed to ensure service users privacy was protected. 10(2)(b) The provider had failed to support the autonomy, independence and involvement in the community of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1) The provider had failed to ensure care and treatment was provided in a safe way for service users. 12(2)(a) The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment. 12(2)(b) The provider had failed to do all that was reasonably practicable to mitigate any such risks. 12(2)(g) The provider had failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet service users needs. (2)(a) The provider had failed to ensure staff

received appropriate support, training, and professional development to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) The provider had failed to establish and operate effective systems or processes to ensure compliance with the regulations. (2)(a) The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (2)(b) The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (2)(c) The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

Issued a warning notice to the provider and registered manager for the breach of Regulation 17 Good Governance.