Royal Mencap Society

Farm Lane House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Farm Lane is a residential care home providing care and support to people with a learning and physical disability. Most of the people who lived at Farm Lane had complex health and care needs. The service is registered to provide personal care and accommodation for up to nine people. On the day of our inspection, eight people were living at the service.

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/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People's experience of using this service and what we found
People told us they liked living at Farm Lane House and relatives we spoke with did not raise any concerns about the care their loved ones received.

We found the service was not operating in accordance with the regulation and was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

Right support:
People were not always supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests. People were not involved in a meaningful way in the development of their care and support and information was not always provided in a way which met people's individual communication needs

Right care:
Care was not always provided in a person-centred way which promoted people's dignity, independence or human rights. People's care and support plans were not always reflective of their range of needs.

Right culture:
The culture of the service did not reflect best practice guidance and we found elements indicative of a closed culture. For example, there was a disabling culture in the service which was embedded in staff practice. There were low expectations for people, a lack of purposefulness to people's day, people's opinions were not always valued nor were they empowered to speak up.

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 07 February 2018).

Why we inspected
We received concerns in relation to safeguarding, the management of risk, people's medicines, the culture of service and governance. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe effective and well led sections of this 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 farm Lane House on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, person centred care, the need for consent, notifications and governance at this inspection.

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

Follow up
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.

We will meet with the provider and request an action plan 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.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Farm Lane House

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 team consisted of two adult social care inspectors, an assistant inspector, a medicines inspector and an Expert by Experience who had consent to gain feedback on the care provided by the service from people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Farm Lane House 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
The first day of this inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

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.

During the inspection
We spent time with and spoke with eight people living at the service, four relatives, 14 members of staff, the registered manager and the area operations manager. To help us assess and understand how people's care needs were being met we reviewed seven people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems. We also spoke with and received feedback from partner agencies.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, policies and procedures and we spoke with members of Mencap's executive management team and representative from the local authority.

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.

Systems and processes to safeguard people from the risk of abuse
Prior to the inspection the Care Quality Commission received concerns that some people's rights were not being upheld and some staff did not respect and maintain professional boundaries when working with people they supported. This information was shared with Plymouth City Council prior to the inspection who are in the process of investigating those concerns.

• People were not always protected from the risk of abuse and/or improper treatment.
• The provider had clear policies and procedures in relation to safeguarding adults and the use of restraint. However, we found safeguarding processes did not always operate effectively.
• Records for one person indicated the registered manager had failed to report to the local authority an allegation of poor practice by a member of staff.
• An investigation completed at the time failed to fully consider the impact this incident may have had on the person; take appropriate action with all staff involved; see this as a learning opportunity or document the rationale for any action taken. We discussed what we found with the registered manager who acknowledged they should have shared this information with the local authority and documented the action they took. We have shared our concerns with the local authority's safeguarding team.
• Eight of the 14 staff we spoke with told us they did not have confidence that action would be taken if they raised concerns. For example, one staff member said they had raised concerns regarding the alleged conduct of an agency staff member towards a person living at the service. They said, "Nothing happened and the person still regularly worked at the service and with this person." The registered manager told us they had spoken to the agency member of staff about their alleged mocking behaviour. However, they had failed to record the allegation or any action they had taken, report it to the staff members employer or the local authority to allow for further investigation and follow up. We have shared our concerns with the local authority's safeguarding team.
• The registered manager and staff had received training in safeguarding and were able to tell us the correct action to take if they suspected people were at risk of avoidable harm or abuse. However, where the registered manager and some staff had known concerns, they failed to raise/escalate their concerns within the organisation or to Plymouth City Council's safeguarding team in line with the providers safeguarding policy.
• Where the registered manager had taken action following concerns being raised, we found they failed to follow the providers safeguarding policy. For example, in August and September 2022, following allegations by staff, the registered manager failed to follow one of the key principles of the providers safeguarding policy, 'Making Safeguarding Personal' (No decision about me without me). In that they never asked the person about the alleged incident or involve them in the process. The registered manager was unable to tell us why they had not spoken with people regarding the alleged concerns or sought their views regarding any

outcomes.

The failure to protect people from abusive practices, improper treatment and to effectively establish systems to investigate and report allegations of abuse placed people at an increased risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Two people who were able to share their views with us told us they liked living at Farm Lane House. One person said, "I like living here, staff take me out." Another replied, "Yes" when we asked if they were happy living at the service.
• Relatives did not raise any concerns about people's safety. Comments included, "Safe, very much so, they're wonderful with [person's name]", "[Person's name] is so safe there" and "Yes [person's name] definitely safe there yes."

Assessing risk, safety monitoring and management
Prior to the inspection the Care Quality Commission received concerns around the management of risks. This information was shared with Plymouth City Council prior to the inspection who are in the process of investigating those concerns.

• People were not always protected from the risk of harm.
• One person was unable to eat or drink and was supported to receive their nutrition, hydration and medicines through a tube in their stomach called a PEG (percutaneous endoscopic gastrostomy). Their care plan and risk assessment contained detailed guidance from the dietitian for staff to follow to ensure the person received adequate nutrition and hydration. The regime required staff to give the person a total of between 1500mls and 1600mls of fluid each day, which included regular structured flushes of water to ensure the person remained healthy and did not dehydrate. However, records did not always demonstrate that staff had been giving sufficient fluids and regular flushes. For example, between 27 September and 10 October 2022 PEG feeding charts and fluid intake charts showed the person had not received the required amount of fluids on four days and there were no records of nutrition or fluid intake completed on three days. Staff we spoke with confirmed that flushes of water did not always take place. This meant the provider could not be assured the person was receiving sufficient fluids, which potentially placed them at an increased risk of dehydration. We have shared our concerns with the local authority's safeguarding team.
• One person had been assessed as needing pressure relieving equipment to reduce the risk of skin damage. We found this person's pressure mattress was not set correctly for their weight, which meant they could be at risk of unnecessary skin damage. There was no guidance in this person's care plan or risk assessment to instruct staff on what the pressure mattress should be set at and there was no system in place to ensure the mattress remained at the correct setting. We discussed what we found with the area manager who told us they would ask the district nurse to adjust the setting.
• Following concerns raised about another person skin, staff were instructed to reposition this person every hour to mitigate the risk of this person's skin breaking down. Records showed this person was not repositioned every hour as directed. Staff's failure to follow this guidance potentially placed this person at an increased risk of avoidable harm.
• Where risks had been identified, it was unclear what action had been taken to mitigate those risks and keep people safe. For example, we found the inappropriate use of bedrails, no bumpers [bedrail protectors] and the lack of bedrail risk assessments had placed people at an increased risk of entrapment. We discussed what we found with the area manager who told us they were unaware of the requirement to assess the risks when using bedrails or to provide bedrail protectors.
• We asked the registered manager to take immediate action to ensure peoples safety. Following the inspection, the registered manager confirmed that bedrail risk assessments were now in place, new bumpers had been purchased and bedrails had been removed where they were not required. We have

shared our concerns with the local authority's safeguarding team.
• We did not have confidence in the way the service managed accidents and incidents.
• Records showed on 29th September 2022 staff had recorded a near miss whilst using a ceiling track hoist to transfer one person between their bed and chair. This resulted in the hoist failing; the person falling a short distance [centimetres] and a staff member catching the hoist before it struck the person. Upon reviewing the records, we found it took five days to alert other staff to the near miss, there was no evidence to show the equipment had been checked by a qualified person and the incident record had been signed off by the registered manager whilst they were on leave. We discussed what we found with the registered manager who told us they were not aware of this incident until we brought it to their attention.
• Following the inspection, the provider confirmed the equipment had been checked by a competent person. All staff have been reminded by the provider about their reporting responsibilities and the importance of completing documents accurately.
• Records showed accidents and incidents were being recorded. However, this information was not being analysed or reviewed at service level. For example, the registered manager was unable to tell us how many medicine errors there had been in the last six months. In addition we found two incident forms had been submitted to senior managers that were not accurate and one incident which had not been documented. This meant the provider could not be assured that lessons had been learnt or enough action had been taken to keep people, staff and others safe from harm.

The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or effectively managed. This placed people and staff at an increased risk of avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

• Other risks to people's health and wellbeing were being managed well.
• People were protected from risks associated with their environment as routine environmental checks were regularly taking place.

Using medicines safely
Prior to the inspection the Care Quality Commission received concerns about the management of some people's medicines. This information was shared with Plymouth City Council prior to the inspection who are in the process of investigating those concerns.

• People's medicines were not always stored or managed safely.
• During the inspection we asked the registered manager on four separate occasions to take immediate action to secure people's medicines.
• One person received their medicines through a tube in their stomach called a PEG (percutaneous endoscopic gastrostomy). This person's care records did not provide staff with complete information about how these medicines were to be administered.
• One person living at the service had been prescribed rescue medicines to be used in the management of their Epilepsy in an emergency. We found these medicines were stored in a place which could be accessed by all staff, visitors and people living at the service. We discussed what we found with the registered manager who confirmed, that whilst the medicine needed to be accessible, they had not considered the risks of leaving them on the person's bedside cabinet next to an open door. We have shared our concerns with the local authority's safeguarding team.

The failure to store and manage people's medicines safely is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Where people were prescribed 'when required' medicines, there were person-centred protocols available to guide staff when doses might be needed. Staff spoken with were able to explain how these medicines were used and people's daily notes recorded the reason for administration.
• Staff received training in safe handling of medicines and had their competency checked to help ensure they gave medicines in a safe way.

Learning lessons when things go wrong
• Systems were not fully embedded into care practice or robust enough to demonstrate incidents were effectively monitored, reviewed or used as a learning opportunity.
• The findings of our inspection identified a culture that was not based on learning. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents or learn lessons.

Systems to assess and improve the quality and safety of the service were ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• People were not always protected from the risk and spread of infection.
• We were not assured that all staff were using PPE effectively, safely and in line with best practice guidance. During the inspection we observed four staff not wearing face masks. We brought this to the attention of the registered manager who confirmed they should have been.

The failure to ensure people were always protected from the risk of infection, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have also signposted the provider to resources to develop their approach.

• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was responding effectively to risks and signs of infection.
• 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.
• The provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives told us they were able to visit loved ones regularly and there were no restrictions in place. One relative said, "I'm able to visit my daughter every week." Another said, "We are always made to feel welcome when we visit."

Staffing and recruitment
• People were protected by safe recruitment processes.
• Systems were in place to ensure staff were recruited safely and records confirmed a range of checks including references and disclosure and barring checks (DBS) had been requested and obtained prior to new staff commencing work in the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• Staff were deployed in sufficient numbers to meet people's assessed needs.

Inadequate

Is the service effective?

Our findings

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

At 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.

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). 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 were not supported to make decisions about their care and staff did not fully understand their roles and responsibilities under the Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Safeguards. This meant people who lacked capacity or who had fluctuating capacity, did not always have decisions made in line with current legislation. For example, where restrictions had been placed on people to keep them safe, through the use of lap belts, bedrails or constant supervision, this was not recognised by staff as restrictive practice and people's capacity to consent to these arrangements had not been assessed nor had staff followed a best interests process.
• People's human rights were not always upheld as people were not always supported to have maximum choice and control of their lives. Staff's lack of knowledge and understanding of the Mental Capacity Act, had led to them making the decision to spend people's monies without undertaking mental capacity assessments or best interests' decisions. For example, we noted a number of people had recently had their bedrooms decorated. There was no information to show who made these decisions or how people were involved or consulted about the cost of the decoration.
• Four people were using an external service to access the community on a weekly basis, which they paid an hourly fee for. There was no information to show how people were involved in choosing this service; how often they used this service or how they chose where they went. The registered manager when asked was unable to tell us, who made the decision to use this particular company or if people, were aware that this was a service they paid for. This blanket approach created a disempowering culture in which people's opinions were not valued.

The failure to properly assess and record people's capacity and best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• People were mostly supported by staff who had the skills and experience to meet their needs safely. The provider monitored staff training using a training matrix which identified staff had received training in a variety of subjects such as, safeguarding, emergency first aid, moving and handling and fire safety. However, we noted that none of the staff had received training in dementia, positive behaviour support or epilepsy. This meant the registered manager could not be assured that staff had the necessary skills to carry out their duties. Following the inspection the provider told us that some staff had attended training in the use of buccal midazolam and Epilepsy awareness.
• The registered and area manager told us staff had opportunities for regular supervision and appraisal of their work performance. However, we received mixed feedback from staff regarding the support they received. Some staff told us they felt supported, appreciated and valued by the service's management team. One member of staff said, "I have regular supervision and have always felt very supported here. They [meaning managers] are all so approachable." Another said, "They're all amazing, I couldn't wish for better managers. The door is always open if I need to speak with them."
• Other staff told us they did not have regular supervision and they did not feel supported or valued by the services management team. One person said, "I haven't had regular supervision." Another said, "I don't feel supported as nothing is kept confidential, too many people have close relationships or friendships with the managers outside of this place."
• There was limited evidence available to demonstrate the providers oversight through supervision or appraisal of staff's work performance or the opportunity to debrief following incidents.
• During our discussions with managers and staff we found there were clear gaps in their knowledge for example in relation to the Mental Capacity Act 2005, Deprivation of Liberty Standards, risk management and safeguarding. None of the staff we spoke with were aware of or able to describe the underpinning principles of Right support, right care, right culture guidance (choice, control, independence, inclusion) and how this might increase people's quality of life.

The failure to provide adequate support and training to staff in order to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
Prior to the inspection the Care Quality Commission received concerns about the management of some people's nutrition and hydration needs. This information was shared with Plymouth City Council prior to the inspection who are in the process of investigating those concerns.

• We observed the mealtime experience and found more work was needed to ensure people's mealtime experience was a pleasant and dignified and that people were supported in a person-centred way.
• Although staff had received training in supporting people with their nutrition and hydration needs, it was not evident that staff used this knowledge/information to improve people's mealtime experience. For example, we saw one person being assisted with their meal by a member of staff. We noted the member of staff did not speak to the person while they were assisting the person to eat their meal, they were chatting to other staff who were present in the dining room at the time.
• We observed another member of staff placing a blue disposable apron upon another person prior to their meal. There was no interaction or discussion with the person prior to putting this apron on.
• During the inspection we observed two people who were unable to help themselves to drinks and snacks were left for two and a half hours without being offered a drink. When drinks were offered, they took a long

time to arrive. For example, one person waited 35 minutes after being offered a drink before it arrived.
• People's care records highlighted where risks with eating and drinking had been identified. For instance, where people needed a soft or pureed diet, this was provided in line with their assessed needs and staff were knowledgeable about the extra support that some people might need. However, we observed that where people required pureed diet, each food item was not processed individually to enable people to enjoy the separate flavours of their meals. For example, we observed and staff confirmed, they had pureed spaghetti, egg and corned beef together for one person's lunch.
• Some staff told us that people regularly had different foods blended together. We discussed what we found with the registered and area manager who told us this was not what usually happened and that they were disappointed that staff were continuing to do this, as they had been told to prepare each food item separately.

This was a breach of regulation 9 (Person-centred care) 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
• Staff failed to keep accurate and contemporaneous records of advice they were given by healthcare professionals following referrals they had made. For example, records for one person showed staff had requested referrals to the GP and community nursing team following concerns about the person's health. However, no further information was recorded; staff did not know when asked if a healthcare professional had seen the person; what advice had been given or if the health concerns were still present.
• We discussed what we found with the registered and assistant managers who were unable to provide assurance that action had been taken and accepted the current standard of record keeping was not good enough. We have referred what we found to Plymouth City Council's safeguarding team for further investigation and follow up.

The failure to complete accurate records of the care and treatment provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other records demonstrated that people were supported to access a range of health care professionals to enable them to live healthier lives. Guidance had been included in people's care plans. This helped to ensure staff had a good understanding of how people should be supported to manage any existing health condition or change in their needs.
• Relatives told us the registered manager and staff communicated well with them and kept them updated when things had changed. One relative said, "They're ever so good, they let me know everything, I'm always informed and I phone them about 3 times a week." Another said, "They keep me so up to date. They phone me, anything at all, appointments and so on."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to admission. Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practice. Information from these assessments were mostly used to develop individualised care plans and risk assessments which provided staff with guidance about how best to meet those needs in line with people's preferences.
• However, we found as some people's needs had changed their care plans and risk assessments remained unchanged, this meant staff did not always have the most up to date information. For example, staff told us that one person living at the service was non-verbal and deaf. We noted this person's one-page profile did not contain this information. Another person's care records indicated they could still do some simple cleaning jobs such as dusting, polishing, emptying their bin and should be encouraged to take part in

cooking activities. Staff we spoke with told us this was not a true reflection of this person's current abilities.

Adapting service, design, decoration to meet people's needs
• Farm Lane House is a detached property situated in a quiet residential area of Plymouth. The design and layout of the service was suitable and appropriate to meet the needs of the people living at the service. Facilities were all on one level, which meant people were able to easily access the home and their private space such as bedrooms. Specialist equipment in bedrooms and bathrooms meant people could have their individual needs met. The service was clean, free from clutter and the registered manager told us the provider had recently carried out a significant refurbishment of the property which included a new kitchen and bathrooms.
• People's bedrooms were personalised with ornaments, pictures and other memorabilia to make them feel more at home and reflect their personalities.

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.

Prior to the inspection the Care Quality Commission received concerns about the management and culture of the service. This information was shared with Plymouth City Council prior to the inspection, who are in the process of investigating those concerns.

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

• During the inspection we received feedback from some staff who described a closed culture within the service, this included bullying, intimidation and a fear of raising concerns due to recriminations. Staff told us this was because of the nature of personal relationships/friendships within the service and the lack of confidentiality. Given the concerning nature of those concerns, we shared this information with Plymouth City Council and the providers senior leadership team, who provided reassurance with regards to staff's wellbeing and assured the Commission these concerns would be independently investigated. Following the inspection, the provider told us they had been unable to substantiate these allegations but they had suspended and redeployed a number of the team. These suspensions included staff members they had previous concerns about, prior to the CQC inspection.

• The culture of the service did not reflect best practice guidance for supporting people with a learning disability and/or autistic people. Neither the registered manager or staff fully understood Right support, right care, right culture guidance published by CQC, or how the underpinning principles could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhanced their expectations, increase their opportunities and value their contributions.

• We identified a poor culture where there were low expectations for people and a lack of purposefulness to people's day. For example, we observed some people were left for long periods of time staring out the window or left to fall asleep in chairs with limited interactions from staff.

• Whilst we saw people did take part in some meaningful activities such as, going to the theatre or out on a boat trip. Staff described trips to the 'shop' or to buy their own birthday presents, as examples of a meaningful day. This was not in line with best practice guidance and evidenced a lack of understanding of how people should be supported to have access to activities and services.

• There was a disabling culture in the service which was embedded in staff practice. Staff were task focused, and did not always encourage, support or empower people to be as independent as possible. For example, we saw staff assisting people without explanation or engagement.

• People were not truly involved or seen as partners in their care. There was limited information to demonstrate how staff were engaging with people in understanding their rights, supporting them to have increased opportunities or enabling them to make informed decisions.

• People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The registered manager did not demonstrate the competency required to manage the regulated activity or have sufficient oversight of the service to ensure people received care and support that promoted their wellbeing and protected them from harm.
• Although the provider had in place a set of policies and procedures, these were not always being followed by the registered manager. For example, the registered manager failed to follow the providers safeguarding policy as detailed in the safe section of this report.
• Poor judgements/decision making potentially placed people at the risk of harm or risked compromising their human rights. For example, in relation to safeguarding people from the risk of abuse or avoidable harm; working in line with the principals of the Mental Capacity Act 2005 (MCA) or keeping complete and accurate records.
• The culture of the service did not reflect best practice guidance for supporting people with a learning disability and/or autistic people. The registered manager failed to engage with people in a meaningful way that would empower them to speak up, which created a closed culture.
• The registered manager seemed to be unaware of the culture within the service and had not recognised this as something that needed to be addressed/challenged. Following the inspection, the provider told us the manager was aware of performance and conduct issues within parts of the team prior to the inspection. There were open HR (human resources) cases in relation to several of the issues that had been identified by the inspector during the inspection.
• The registered manager was aware of their regulatory responsibilities but failed to carry them out. For example, in relation to notifying the Commission and local authority of significant events that had occurred within the service.

The failure to manage the service in accordance with the regulations was a breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• Governance processes were not effective in keeping people safe, protecting people's rights and providing good quality care and support. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. Issues included concerns with regards to leadership, safeguarding, training, management of risk, nutrition and hydration, mental capacity and person-centred care.
• Systems and processes could not be relied upon to ensure people received adequate nutrition and hydration. For example, the registered manager had failed to identify that one person was not always receiving adequate hydration through their PEG, as they did not carry out any additional checks.
• Systems were not fully embedded into care practice or robust enough to demonstrate incidents were effectively monitored, reviewed or used as a learning opportunity.
• Systems and processes had not identified that staff had failed to keep accurate and contemporaneous records of the care and treatment people received or that some care records were not reflective of people's needs.
• Governance systems and processes had not identified that records were not always accurate or fully completed. For example, information relating to safeguarding incidents could not be found. This meant the

provider could not be assured that lessons had been learnt or enough action had been taken to keep people, staff and others safe from harm.
• Governance systems had failed to identify that staff were not following the service's policies and procedures for example, in relation to safeguarding, accidents and incidents, medicines, PPE, notifications, mental capacity, bedrails and specialist mattresses

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

Following the inspection the provider confirmed they had taken action to increase their oversight and provided additional resources to support the day to day management of the service. For example, the provider instructed three members of their quality team to carry out a full review of the service and produce an improvement plan. These staff were also tasked with providing ongoing support, advice and practice leadership. The provider also carried out an internal investigation into the whistleblowing concerns.
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 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. However, systems had not been effectively operated to identify and report all significant events. This had led to the provider not notifying the Care Quality Commission of some significant events, which had occurred in line with their legal responsibilities.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The registered manager told us they met with people living at the service regularly and kept in contact with relatives. However, there was no evidence that people's or relatives' views were being used to develop and shape the service.
• Relatives we spoke with continued to have confidence in the service and told us the service was well managed. Comments included; "The manager is brilliant – absolutely", "I'm very happy with the new manager, she tells me everything. She is very calm" and "I've only met the current manager once, she introduced herself when she took over. She seemed approachable and friendly."
• Two assistant managers and a team of support workers supported the registered manager. Each had recognised responsibilities and there were clear lines of accountability.
• The registered manager told us they had a good working relationship with senior managers, they felt valued and supported.
• Regular meetings and handovers helped to ensure information was shared.
• The service had developed working relationships with other health and social care professionals which meant advice and support could be accessed as required.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the Care Quality Commission of all significant events, which had occurred in line with their legal responsibilities. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure staff provided person-centred care and support. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the principles of the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were protected from the risk of avoidable harm.

You failed to assess and take action to mitigate the risks associated with the use of equipment.

You failed to ensure people's medicines were stored and managed safely.

You failed to ensure service users, staff and visitors were protected from the risk and spread of infection.

Where risks had been identified, you failed to take sufficient action to mitigate those risks and keep people safe.

Regulation 12 (1)(2)(a)(b)(e)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been operated effectively to protect people from abusive practices and to investigate and report allegations of abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Systems to assess and improve the quality and safety of the service were ineffective. The failure to complete accurate records of the care and treatment provided Regulation 17 (1)(2)(a)(b)(c)(f)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager failed to manage the service in accordance with the regulations Regulation 7(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider to failed to provide adequate support and training to staff in order to meet people's needs. Regulation 18 (2)