Centurion Health Care Limited

Penley Grange

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

Summary of findings

Overall summary

About the service
Penley Grange is a residential care home. The service was supporting five people at the time of our inspection and can support up to six people. The service is adjoined to a separately registered care home operated by the same care provider.

People's experience of using this service and what we found
People did not always live safely. This was because the service did not assess, monitor or manage people's safety well, including risks of abuse and risks posed by the behaviours of people using the service. The service had failed to consistently make contact with other relevant agencies, when incidents or concerns occurred, to protect people from the risk of abuse. Where concerns had been identified and reported, this had not always been achieved in a timely manner.

Staff members did not always treat people with kindness, dignity and respect, including respect for people's privacy. People were not consistently supported to express their wishes and engage with staff using their preferred methods of communication.

Staff recruitment, induction and ongoing training processes did not promote safety, including those for agency staff. The skills and deployment of staff did not match the needs of people using the service.

People did not have opportunities to learn new skills or try new experiences due to the limited variety of on-site and off-site activities people were supported to participate in. Care plans were not holistic, strengths-based and did not capture people's preferences and aspirations. We have made a recommendation in relation to end of life care planning.

People's relatives told us they had generally been involved in key decision making, however records showed the service did not consistently consult people's relatives when accidents or incidents occurred. Relatives felt communication could be improved, although indicated there had been some recent signs of improved communication since a care consultancy was engaged to help manage the service, including contact with relatives about some incidents which had occurred.

Governance processes had not been operated effectively to keep people safe, provide good quality care and protect people's rights. A care consultancy had recently been commissioned by the provider to develop an action plan and support the service to make improvements. At the time of our inspection we observed environmental works taking place but a number of other planned changes had not yet been implemented, or were not yet embedded, meaning we could not observe significant improvements to people's experience of using the service. We have also made a recommendation in relation to the provider's responsibility to meet the duty of candour.

People were not supported to have maximum choice and control of their lives and staff did not support

them in the least restrictive way possible and in their best interests; the service had purchased a new suite of policies which were due to be implemented to promote best practice.

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.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support
People were not consistently supported by staff to pursue their interests, or to identify their aspirations and goals. Staff did not always communicate with people in ways that met their needs. People were not supported in a safe, well-maintained environment that met their sensory needs.

Right Care
People did not always receive kind and compassionate care. Staff did not consistently take action to protect and respect people's privacy and dignity. Staff did not consistently understand and act to protect people from poor care and abuse.

Right culture
People were not supported to lead inclusive and empowered lives. The service had failed to consistently evaluate the quality of support provided to people or ensure risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity.

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 8 November 2017).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. The inspection was prompted in part due to concerns about poor management oversight following concerns raised about the quality and safety of people's care at the adjoined care home. We had also received concerns in relation to the service, including concerns about the quality of people's care, staff culture and management of risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Penley Grange on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care, safeguarding from abuse, person centred care, dignity and respect, consent to care, staffing levels and suitability, nutrition and hydration, suitability of the environment, management of complaints, staff training, governance and leadership and reporting of incidents.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an updated 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.

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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Penley Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
Two Inspectors, a member of the CQC medicines team and an Expert by Experience carried out the inspection. 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
Penley Grange is 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. Penley Grange 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
The service's registered manager was no longer in post at the time of our inspection, and was not involved in the inspection process. Where a manager is registered with the Care Quality Commission, 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service in the last 12 months. Partner agencies were undertaking regular monitoring visits to services operated by the provider, due to concerns recently identified in relation to the provider's adjoined care home. We reviewed the feedback from professionals following these visits. We also reviewed an action plan which had been shared by the provider.

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.

This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with or observed five people who used the service and five relatives about their experience of the care provided. Where people were unable to speak with us, we spent time observing people's body language, facial expressions and vocalisations, to help us understand their experiences of using the service.

We spoke with 19 members of staff including 12 support workers, the acting team leader, the on-site care consultant, the director, three regular agency staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and five people's medication records. We looked at five staff files in relation to recruitment and a folder of collated staff team supervision records. A variety of records relating to the management of the service were reviewed, including files relating to compliments and complaints, accidents and incidents, safeguarding, staff training, minutes of staff and resident meetings, audits, staff handover records, and evidence of COVID-19 testing.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures. We requested additional evidence from the nominated individual, including feedback about the calculation of staffing hours. We received email feedback from several professionals including environmental health, the fire service, GP surgery and records of ongoing monitoring visits conducted by partner agencies.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● We reviewed safeguarding records from 2018 until the recent departure of the registered manager. There was no system in use to log, monitor or investigate safeguarding concerns. The registered manager had failed to report concerns to the local safeguarding authority as required.

● On 19 April 2022 we found four safeguarding referrals had been submitted since the start of April 2022. The safeguarding log and documented referrals did not include incidents logged on 1 April 2022 and 7 April 2022 where a person had slapped and hit other people using the service. The April 2022 safeguarding log did include five concerns which were marked as 'open'. This indicated some improvement in reporting and recording, however this was inconsistent; incident report forms continued to be incomplete and did not contain enough information about how the service was managing safety effectively.

● Incidents on 23 April 2022 and 24 April 2022 were not reported to the local authority until 11 May 2022. This meant we could not be assured the service was identifying, responding to and reporting safeguarding concerns in a timely manner. The nominated individual advised on some occasions staff failed to complete the correct documentation which had contributed to delays.

● Some staff used incident/accident forms to log potential safeguarding concerns, frequently completing page one of three only. The care consultant was not aware of pages two or three of the forms, and told us they did not sign the forms to confirm they had been reviewed and did not make comments on the forms about actions taken to demonstrate how people were safeguarded.

● We identified a body chart dated 4 April 2022 showing scratches to one person's back. The document provided no explanation about how the scratches occurred and the nominated individual confirmed no investigation was completed. Another body chart, dated 3 April 2022 showed unexplained bruising around a person's eye. The bruising had been reported to the local authority safeguarding team. There was no accessible record of an internal investigation to explore the potential cause of the bruising and therefore we could not be assured the service had taken all reasonable steps to consider any potential measures which could be implemented to safeguard the person.

● People were not protected from risks of abuse associated with people's behaviours. We observed one person push another person on their shoulder. The push did not appear to be forceful but the person who was pushed looked around and had a worried expression on their face. The agency staff member present did not acknowledge this with either person. The staff member followed the person around, rather than engaging the person in meaningful activities or anticipating the potential risk of the person hitting or grabbing others.

● During inspection visits the same person consistently pushed, grabbed and pulled inspectors forcefully. We also witnessed a person being hit, a contractor was pushed and a staff member was forcefully pushed against a door. Staff supporting the person did not consistently implement identified preventative strategies or respond effectively to early warning signs to take steps to prevent behaviours from escalating. We

observed occasions where staff were following the person and then once the person had already engaged in distressed behaviours, staff told the person to stop, let go or held the person's hand and tried to lead them away. One person told us they felt upset when the person shouted. There was an ongoing risk of distress and injury to the person and others. The nominated individual told us the number of different visitors to the service throughout March 2022 onwards contributed to the person feeling unsettled. This was not reflected in the person's care plans and risk assessments at the time of our visit. Staff and the nominated individual also described other triggers for the person's actions, including boredom.

● Staff we spoke with had varying levels of understanding in relation to signs of abuse and how to escalate concerns. Records showed safeguarding training was up-to-date for only four of 15 staff, with training for other staff being incomplete or overdue refresher.

Systems and processes were not established and operated effectively to prevent abuse of service users or to investigate concerns. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was in place. This stated the service would review the previous three months incident records to identify safeguarding concerns. Prior to our inspection the nominated individual had also requested information from the local authority to cross reference with internal information. The service advised a care plan review had been undertaken in relation to the person who made physical contact with others; a medicines review had been requested prior to our inspection. On 3 May 2022 the local authority shared details of an online learning resource with the provider to help improve staff understanding of how to identify and respond to concerns of abuse or neglect. The provider confirmed all staff would be asked to participate in the recommended learning.

● One staff member demonstrated a good understanding about signs of abuse, explaining they would pay attention to concerns such as unexplained bruising or changes in behaviour. The staff member knew how to escalate concerns. They told us, "Would let manager know about it, if manager doesn't act...can whistle-blow [escalate concerns externally]."

Assessing risk, safety monitoring and management

● Risk assessments were either not present, had not been updated in a timely manner, or lacked sufficient detail to help staff understand and respond to risks. Four people's care records contained an undated risk document entitled "How to support [person] safely", which rated hazards as low, medium or high. There was no explanation or rationale about how respective ratings were assessed. For example, there was no reference to the likelihood of occurrence or severity of outcome. There was no evidence the risk assessments had been subject to regular review.

● One person's care file contained a positive behaviour support (PBS) plan, dated 11 November 2021. The PBS plan stated staff should move other people away to maintain safety. There was no information about how to do this or what to do if other people declined to move. A staff member told us they would use their body to come in between the person and others, saying to the person, "pushing is no good". This intervention was not documented in any of the person's care plans or risk assessments. There was another 'Behavioural support plan', undated, which stated if the person pulled at staff they were to tell him "Hands down". This was not included in the PBS plan dated 11 November 2021. Both documents were in the person's file and it was unclear which one staff should follow, which meant staff may not know how to support the person appropriately to prevent and reduce the risk of harm.

● Another person's risk assessment did not consider their potential risk of falls. A staff member advised the person used the stairs slowly. They explained they monitored to ensure they were using the banister and reminded them to be careful when placing their feet. Incident records showed the person had recently fallen

on the stairs. There was no evidence a risk assessment had been carried out in response to the fall.

● Staff practice placed people at increased risk of harm. We observed two staff members assisting someone to stand from a trampoline, placing their hands under the person's upper arms. This was not done forcefully. Another staff member told us they held the person's hands to help pull them up. These approaches could have placed the person or staff at risk of injury. Care records contained no risk assessment or guidance about how to assist the person to stand. Records showed moving and handling training was incomplete or overdue refresher for all but one member of staff.

● Another person's risks in relation to epilepsy were not well managed. The staff notice board included an undated seizure protocol which referred to rescue medicine. The person's care folder included an epilepsy risk assessment but did not refer to rescue medicine. There was no supply of rescue medicine on-site and a prescription was requested in response to our feedback. We asked a staff member how they would respond to a seizure. They could not locate written guidance, and told us they would shout at the person to wake up, and if they didn't respond would call an ambulance. This was not in line with the protocol or risk assessment.

● Another person experienced a visual impairment. A risk assessment advised they were at risk of tripping or falling over unseen objects and described support required in the community. There were no risk reduction measures in relation to the service. For example, the assessment did not consider use of stairs, the uneven garden or risks the person was unable to see another person approaching who was known to physically assault them.

● Another person's care plan confirmed they had a diagnosis of epilepsy. We asked four members of staff and one agency staff, who had a history of epilepsy. Staff did not identify the person. The person's care plan contained a general information guide about epilepsy, describing different types of seizures, treatments and triggers. The information was not personalised, meaning there was no information about the person's past history of epilepsy, such as when their last seizure occurred.

● Chemicals or substances hazardous to health (COSHH), were not safely stored. We found chemicals in a kitchen cupboard which had no lock and were advised people had supervised access to the kitchen which was accessed via a keypad. We twice found laundry detergent in an unlabelled jug on the floor of the laundry room. The laundry room was secured with a single bolt at the start of our inspection and on some occasions was found unlocked. On a subsequent visit to the service the laundry room bolt had been replaced with a keypad lock. We found tubs of paint left outside in the garden. On another visit we found an unlocked cupboard containing hand sanitiser.

● There was no legionella risk assessment on file. Water temperature monitoring, and flushing of infrequently used water outlets, was not correctly implemented to monitor and prevent the risk of legionella. We also checked water temperature charts for baths and showers dated April 2022 for the prevention of scalding. The records contained several gaps without explanation, meaning we could not be assured staff consistently checked water temperatures in line with procedures.

● The service's previous fire risk assessment report, dated June 2019, identified several actions with no evidence of these being achieved, such as the training of fire wardens. The service's recent fire risk assessment report, dated March 2022, also made a number of recommendations, including the need for evacuation drills during sleeping hours which had not taken place at the time of our inspection. We reported our concerns to the fire service who visited the service. Their report made a number of recommendations, and after our inspection the service provided evidence to confirm some processes were in place, such as the maintenance of fire alarms. Records showed the last fire drill was 29 June 2021. This meant new staff had not participated in a fire drill. Every 'fire alarm weekly test' between 15 November 2021 and 4 April 2022 documented the magnetic door release on the dining room door was not working. The home's maintenance book included an entry dated 20 January 2022 that the fire doors needed repair in the dining room, two bedrooms, TV room and sensory room. There was no action recorded.

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

An action plan was in place. We were advised all care plans and risk assessments would be reviewed, including positive behaviour support (PBS) plans. The provider had commissioned a care consultancy to assist with the implementation of the action plan. This included support from care consultants to update care plans and risk assessments and we were advised this process would include input from family members and relevant professionals. The nominated individual told us fire marshal training was arranged for 13 June 2022 for all staff and stated they had started the process of going through the fire evacuation procedure with staff during handovers which included agency staff. We were advised other fire safety actions would be addressed.

● We did observe examples of staff responding to risk. One person required a ground floor bedroom and experienced difficulty walking. The person called out to a staff member upstairs and started to walk up the stairs. The staff member responded to ensure the person safely returned to the ground floor. Staff also supported the person to safely negotiate steps into the garden.

Using medicines safely
● There were some systems and processes in place to safely store medicines. However, access to medicines were not always restricted as keys to medicines cabinets were not always secure.
● Staff monitored and recorded the temperature of some medicine's storage areas but not of all. Therefore, we could not be assured that all medicines were stored according to manufacturer's recommendations and if they remained effective.
● People's medicines were not regularly reviewed to monitor the effects of medicines on their health and wellbeing. We saw that not all people had records of annual physical health checks or medicines review.
● People's medicines care and support was not always consistently recorded in their care plans. Where there was information about people's medicines in their care plans, they were not always up to date with current prescribed medicines.
● Most people had one or more medicines prescribed to be administered when required (PRN). However, there was not always enough information for staff to safely and consistently administer PRN medicines.
● Some staff were able to give examples of medicines related incidences. However, it was not clear what learning there was as a result of incidences and how improvements were implemented.
● Not all staff had received up to date medicines refresher training or competency assessment in line with the providers policy. Where staff had received training, they told us that the content of the training was not always relevant to their service type and the medicines they administer. For example, staff had not been trained on how to administer rectal medicines, although there was a person prescribed emergency rectal medicine.
● Medicine audits were carried out regularly. However, the audits were not robust and had failed to identify all the concerns relating to medicine management we found during our inspection.
● Staff did not always follow the provider's Medicines Policy when administering medicines. For example, two members of staff were required to prepare controlled drug (CD) administration and sign the CD register, however we found that two staff were not always signing the CD register.

The service had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an action plan in place. We were advised all staff who administered medicines would be subject to re-training and a review of their competency in relation to medicines support.

● The service had recently purchased and installed a medicines fridge to improve arrangements for medicines storage.

Preventing and controlling infection

● We were not assured the provider was effectively managing risks in relation to COVID-19. We found sign-in procedures were inconsistent. On our initial visit, staff did not ask health screening questions or seek evidence of COVID-19 testing, and inspectors were not encouraged to sign in or sanitise their hands. On another visit we were asked to sign in but needed to prompt staff to view COVID-19 testing evidence. Staff management of the entrance hall did not promote social distancing between people and visitors.

● Staff did not consistently wear face masks when supporting people in close proximity, although the majority of staff did wear face masks appropriately. Throughout our visit on 14 April 2022 the two staff present were not wearing face masks and both were at times in close proximity to a person using the service. On another occasion we observed a staff member sitting next to a person wearing a face mask under their nose.

● We noted two people's care folders included NHS letters to confirm they had previously been identified as clinically extremely vulnerable, however care plans contained no instructions for staff to outline whether additional precautions were still needed to mitigate risk. At the time of our inspection the government had updated national guidance on 1 April 2022 to advise there is no longer separate guidance for people previously identified as clinically extremely vulnerable, although the government recommends anyone with underlying health conditions takes care to avoid routine coughs, colds and other respiratory viruses. There was no reference to whether people were at increased risk of COVID-19 or other viruses in their care plans or risk assessments.

● Cleaning schedules were in place and on one occasion we observed staff using a hoover and sanitising surfaces. However, cleaning schedules, including for the regular sanitisation of door handles, contained several gaps. The oven appeared greasy and had debris in the bottom of it. On one occasion we found mops, used for different tasks, stored touching one another. On 5 May 2022 we identified items in the fridge without open-date labelling and the chart used to log daily fridge and freezer temperatures had not been completed since 22 April 2022.

● We identified concerns regarding the disposal of waste, such as masks, gloves and used lateral flow COVID-19 tests disposed of in bins without bin liners. We also found staff had stored used lateral flow test kits in a cupboard in the office. We found a glove in the rear garden and a mask on the ground.

● COVID-19 testing records were poorly maintained. Prior to the current use of lateral flow tests, government guidance required all staff to undertake a weekly PCR test, which was sent via post for analysis. A staff member explained testing had only occurred on Mondays, which meant some staff had not undertaken weekly testing. Testing records on-site were incomplete. We were advised test results had been issued to the registered manager and were not accessible during our inspection.

● Records for staff lateral flow testing were inconsistent. The care consultancy had recently introduced a log for lateral flow tests, to be monitored as part of daily checks. However we could not be assured of the effectiveness of these checks, as on 19 April 2022 we found the care consultant was not aware of who was on duty and the employee sign-in sheet did not match the full list of staff we observed working.

● The COVID-19 policy appeared to be missing key information. The contents list referred to topics such as 'admissions to the care home', 'visitors' and 'diagnosing COVID-19 in care homes' however there was no content about these areas. We located a visitors policy dated 30 July 2021, however there was no evidence this had been updated in response to subsequent changes to government guidance.

● The provider shared a risk assessment form entitled 'CORONAVIRUS(COVID-19)', dated 10 January 2022,

which included measures to reduce risk. We found these were not always implemented. For example, there were no staff risk assessments on file and reception areas did not have suitable controls to protect visitors.
● The nominated individual confirmed the log for staff vaccine uptake was blank. This meant we could not evidence how the registered manager had verified whether staff had been fully vaccinated against COVID-19. Whilst there was no longer a legal requirement for care staff to be vaccinated as a condition of deployment, information regarding vaccine uptake can assist with assessing risk, such as considering risks for service users, particularly those who were identified as clinically extremely vulnerable.

The service had not established or implemented robust infection prevention and control procedures to effectively mitigate risk to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place. This identified the need for fly screens to be fitted and for monitoring to ensure bin liners were used. The provider had purchased a suite of policies which were due to be implemented, which included policies for infection control and admissions policy and procedure.

● Staff informed us they had access to sufficient personal protective equipment (PPE) and lateral flow COVID-19 test kits.
● Records and feedback highlighted that staff had received incorrect guidance about the use of gloves during the pandemic. A staff member told us the registered manager was "very strict" about staff wearing gloves at all times. This was not in line with best practice PPE guidance. The care consultant told us this had been addressed with staff and we generally observed staff wearing gloves appropriately during our visits.
● Concerns had been raised about waste bins. A family member told us, "At the entrance the bins were overflowing with bags, in the COVID period, and managers could've done much more to control this. I'm not sure if it's addressed even now because they are still regularly there." During our inspection we did not see overflowing bins, and the service's action plan stated a bin store compound would be developed.

Learning lessons when things go wrong
● A 'read and sign' process informed staff about important updates. We consistently found not all staff had signed to confirm they had read updates and there was no evidence gaps had been addressed. For example, a staff 'read and sign' document from March 2021 had been signed by six of the 15 staff listed.
● We observed the use of 'tick sheets' to document behaviours. Staff ticked against handwritten headings such as 'hit staff', 'punching and 'screams'. Tick sheets recorded the date of incidents with no further information. We were advised the 'tick sheets' had been introduced by a visiting professional as an addition to the service's own internal processes for incident reporting. We crossed referenced tick sheets with incident forms and found these had not been completed for several 'ticked' incidents. This meant there was no evidence these incidents had been reviewed to explore antecedents and take steps to prevent reoccurrence.
● Where incident forms were completed, there was no evidence of management oversight of individual incidents to assess or mitigate the risk of harm to people, staff and others. There was a summary log to note incidents for each person, however the column entitled 'action planned' was frequently left blank.
● There was no evidence in the accident/incident file, complaints file or safeguarding file about how the service audited or analysed incident reports over time, to identify potential themes and strategies or lessons learnt to prevent and reduce reoccurrences.
● On 23 March 2022 the manager advised an incident had occurred where a person was left unattended in a bath. On 13 April 2022 the nominated individual explained there was no documentation about the incident, and the staff member was away, meaning it wasn't possible to complete an investigation. The person's risk assessment, which was undated, identified hazards such as slipping when getting in and out of the bath. It

stated, 'check water temperature' and 'never leave [person] unsupervised'. A staff member told us the person must never be left alone in the bath as there was a risk of the person 'opening' the taps and scalding himself. This was not identified as a hazard in the risk assessment.

● Incidents were logged on 7 April 2022, 15 April 2022 and two occasions in June 2021 where a person had overturned a table. There was no evidence of management oversight of any of these incidents and the care consultant advised staff hadn't discussed the recent incidents with them. The person's care plan and risk assessments did not refer to the behaviour, meaning there was no written guidance to advise staff how to mitigate risk.

Risks to people were not clearly identified and managed, and systems were not operated to promote learning from incidents to mitigate risks to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place. We were advised the care consultant would review the previous three months incidents to identify potential safeguarding concerns. The care consultant advised monthly analysis of accidents and incidents was due to commence. The service had purchased a new suite of policies, meaning an updated accidents and incidents policy would be implemented. Following our inspection the provider advised the 'tick sheets' had been subject to further investigation and we were informed staff could not recall two 'ticked' incidents where people had been allegedly hit by another person using the service, and it was therefore believed the ticks were in the wrong box. The 'tick sheets' were subsequently withdrawn.

Staffing and recruitment

● The service did not ensure people were supported by staff who had been subject to appropriate recruitment checks. The service did not seek applicants' full employment history, and we found no evidence gaps in employment history had been explored. One file did not include an application form and two application forms were partially completed. One staff member's proof of address did not match the photographic ID they had provided.

● We found one staff member's references obtained in 2017 and another staff member's references obtained in 2018 had not been verified until 2022. References were marked with a handwritten note 'verified', without any details about how this was achieved.

● The provider's recruitment policy stated a minimum of two references were required, if at all possible based on previous employment, and if the referee was personal, if possible have some standing in the community, and if in doubt to seek three references. We found the policy was inconsistently followed. For example, one staff file contained a character reference, and the second reference did not state in what capacity they knew the applicant. There were no risk assessments or written explanations about decisions to appoint staff without appropriate references.

● The provider's interview process was not designed to demonstrate the candidate's skills to support people with a learning disability. The questionnaire contained basic questions such as, "What difficulties might someone with autism have?" but did not ask questions about person-centred care, relevant legislation or equality values. One staff file did not contain an interview record. Where another applicant indicated they had no experience, and only partially met criteria for nine of the interview questions, there was no explanation as to why they were recruited.

● 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. For three staff we found a DBS number handwritten onto the staff member's file, meaning we could not establish the date of the check, whether the DBS barred list had been checked, and whether a manager had checked the certificates were satisfactory.

● The nominated individual explained original DBS certificates had been destroyed after the service was advised they could not retain copies, however it appeared this had been inconsistently implemented, as some DBS certificates were found in a filing cupboard during our inspection.
● One DBS check showed previous convictions. The staff member commenced work in 2014 and the risk assessment on file was dated 2017, last reviewed in 2018. The risk assessment contained inaccuracies in relation to references. The staff member regularly worked without management supervision and no supervision records were accessible at the time of our visit. The staff member had failed to fully complete the job application form and the interview record advised they had no knowledge of autism. We were not assured a robust recruitment process had been followed.
● We reviewed profiles for agency staff who had recently worked at the service. Some of the profiles did not contain DBS numbers and none of the profiles indicated staff had experience supporting people with learning disabilities. We spoke with one regular agency staff who confirmed they had not received training about learning disabilities, autism, or supporting people's behaviours. We were not assured the suitability of agency staff had been sufficiently checked prior to work.
● There was no evidence the service had considered applying for overseas criminal checks where a candidate's application indicated their previous employment 2013-2018 was overseas. Overseas criminal records checks are considered good practice as part of safe recruitment processes to help assess whether a candidate is of good character.

Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual stated an audit of staff files would be conducted. The nominated individual confirmed the staff member's DBS risk assessment had been reviewed and would be updated. The nominated individual advised the agency had been approached to request updated profiles. The provider had purchased a new suite of policies, including a new recruitment policy, which was due to be implemented.

● The director explained staff funding levels were agreed with commissioning bodies when people moved in and described the information as "quite historical". The director confirmed formal systems, such as a dependency tool, had not been used to regularly review whether funding provided sufficient staffing. They explained staff ratios had been agreed with the local authority when people moved to the service, or as people's needs changed. The nominated individual told us they had contacted commissioners to request a funding review.
● Staff described an impact to people when staffing levels weren't maintained. Two staff members explained during the previous month, when a recently departed manager had been in post, there had been instances of short staffing, where three staff had worked, instead of the allocated five staff. A staff member explained when the service was short staffed activities couldn't take place and stated three people would be "left for [the] duration of [the] shift" because two people needed "a lot of time and attention". Recent rotas showed there were sometimes less staff working between 7am and 9am due to staff contracted hours. A staff member described working between 7am and 9am with one agency worker which they stated was insufficient. They explained breaks and cleaning could not always take place when short staffed.
● There was a lack of continuity for staff deployment where people required one to one support. A staff member supporting a person told us they would likely support the individual either for 10 minutes, 20 minutes or one hour, adding someone else would come after, explaining it "depends on how the shift goes". Whilst in some cases people can benefit from a change of staff face, for example following an incident of distress, we were concerned the inconsistent deployment of staff could have caused unnecessary

uncertainty and did not help people to plan a structured day.
● Rotas assigned staff to provide one to one support, but in practice staff agreed their deployment during the shift. The acting team leader explained staff spoke amongst themselves to agree duties, taking into consideration factors such as who had completed personal care tasks the day before and who would cook.
● We found no evidence staff were matched with people based on their skills. Staff without Makaton skills supported people who used Makaton (a type of sign language). One person with complex needs was frequently supported by agency staff. We spoke with two agency workers who told us they had not received training in relation to autism or supporting people's behaviours. We were concerned this arrangement was unsafe. The nominated individual explained rotas had been identified as a concern, and it was believed a culture had developed where there was an expectation female staff would cook and clean, meaning skilled female staff were diverted to domestic duties.

We were not assured enough suitably qualified, competent and experienced staff were deployed to safely meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual explained a staff meeting was planned to speak with staff about the importance of following rotas, or documenting a rationale where a change of staff deployment was necessary. We were advised the provider was committed to changing the team culture to ensure equity of duties for female staff. The provider's action plan noted concerns about reliability of agency staff had been raised with the agency. Following our inspection the provider informed us staff working hours were subject to a consultation process as these had been granted historically prior to the involvement of the care consultancy.

Inadequate

Is the service effective?

Our findings

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

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

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

- We reviewed national malnutrition screening records for five people. Staff failed to enter the information required on the form in order to assess whether people would benefit from a dietitian referral.
- One person's behaviour plan stated the service should display a picture menu board for the day's meal. There was no menu accessible to people in the dining room.
- We consistently observed, and a staff member confirmed, everyone consumed the same food, with adaptations for one person's food intolerance and another person's soft food diet. Menus did not offer a daily choice of main meals, snacks or desserts. A staff member told us when ordering food and developing the menu they "sometimes" asked what people wanted to eat.
- People were not offered day to day choices. At one meal a staff member served everyone orange squash, without asking what people would prefer. When a person asked twice for coffee, the staff member first responded, "Later" and then, "Finish this first and coffee later." On another occasion everyone was served with curry followed by yoghurts. One person asked for jelly but was told they had already been given dessert.

- Observations showed, and staff feedback confirmed, everyone's breakfasts were prepared at the same time. One person got up later and on two occasions we observed their breakfast left pre-prepared in the kitchen. A piece of toast and jam was covered in cling film, which was cold to the touch, and this was taken to the person to eat.
- During a visit we observed people requested drinks and staff responded to this. There had not been consideration about how people could access drinks for themselves, without having to ask staff, such as a water dispenser.
- One person required minced and moist food following a review by speech and language therapy (SALT). SALT guidelines were included within the care folder, however the care plan contained contradictory information which could have placed the person at risk. A photo page of the person's favourite foods included a standard sandwich, standard biscuit and standard portion of sausages and mash.
- Another person's care plan stated they could feed themselves and required a plate guard. The care plan instructed staff to split the person's meal onto two plates to avoid them finishing quickly and disrupting others. The care plan did not state what utensils were required. Throughout our inspection we observed staff did not follow the care plan. One meal was served in a single bowl and staff used a dessert spoon to 'hand over hand' place food into the person's mouth. On another occasion a single plate with plate guard was served. The person finished quickly and disturbed others who were still eating. On a third occasion the person was served chopped food without a plate guard. They struggled to eat with a teaspoon and staff repeatedly removed their hand to put food onto the spoon.

● The person's risk document identified the hazard, "[Person] can so quickly and forget to chew and may choke". This did not make sense as the word 'eat' was omitted. There was no reference to or evidence of a referral to SALT to mitigate this risk. A staff member explained they would tell the person to slow down, however said, "depends on mood…if will listen" and described the person "coughing and spluttering". After our visit we were advised a SALT referral had been verbally discussed with the GP.
● Two other people had identified risks of choking. Within care plans we found no evidence the service had sought guidance from SALT or other professionals when designing risk reduction measures. One person's care plan did not include a risk assessment in relation to their risk of choking. The second person's care plan included an undated risk assessment which stated the person was at high risk of choking. There was no evidence the assessment had been subject to regular review and there was no rationale to evidence how the level of risk was determined.

The service did not consistently identify or meet people's nutrition or hydration needs. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our feedback. We were advised two people had been referred to SALT and contact had been made with the GP surgery about a third person. We were advised the care consultant would observe mealtimes to ensure staff were adhering to care plans, which would be subject to review to ensure measures were appropriate to manage risks of choking. We were advised all care plans and risk assessments would be reviewed and rewritten.

● Most staff were able to provide basic information about people's dietary needs, such as awareness of one person's food intolerance and another person's soft food diet.
● One person had a food intolerance. We observed their foods were stored separately, including a separate container in the freezer.
● There was some fresh fruit observed in the kitchen, although some of the apples appeared old and shrivelled and a staff member explained they would be used for baking. Staff incorporated healthy foods with some meals. For example, people were served salad with a chicken curry. At another meal staff served vegetables with a serving of pizza and chips.
● One person had previously received dietician support. The dietician's discharge report, dated 6 October 2020, noted the person's weight had increased by 11 percent since dietetic involvement. The person's current weight was above the dietician's suggested baseline weight, indicating weight gain was maintained.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care records and the support staff provided did not consistently reflect evidence-based guidance and best practice. For example, the service had not operated a risk assessment process for people's mobility and moving and handling tasks to assess potential risks such as falls, use of the stairs or transfers from low surfaces.
● People's care records contained behaviour support plans. Some were undated and another person's behaviour support plan was dated 1 January 2020. Four people's care records contained no evidence of how behaviours had been assessed, who had been involved in these assessments, or whether reviews of the effectiveness of the plans had taken place.
● There was limited evidence of how the service assessed sensory needs. One person's behaviour support plan noted noise as a trigger. Another person's care plan noted they did not like loud noises. A third person's care plan highlighted noise could cause them to become anxious, which we observed during our visit. One person expressed themselves through loud vocalising and banging. There was no evidence within care plans

as to how the ongoing impact of noise on people's wellbeing had been considered, including whether people's needs had been assessed as being compatible with one another.
● Care assessments had not holistically explored people's sexual health and relationship needs. One person's care plan did not contain information about why they received contraceptive medicine. Staff explained two people separately needed privacy to meet their needs. One person's care plan did not make reference to this, and another person's care plan included this within a behaviour support plan alongside a description of "sexual inappropriate behaviours".
● Care records did not include oral health assessments. Care plans contained basic information such as whether the person needed full support to brush their teeth, without giving details about the type of brush or toothpaste used. One person's teeth brushing record stated they were 'uncooperative' on ten occasions in the morning between 1 and 15 April 2022. There were several gaps in the PM column. Care plans were not updated to include recommendations given by a dentist on 4 April 2022.

The service did not ensure that care plans fully identified or met people's needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place, which stated all care plans would be rewritten and discussed with people's representatives. A care consultant explained the process of consultation with people's relatives had commenced.

Adapting service, design, decoration to meet people's needs
● The service's environment was poorly maintained. Paintwork appeared damaged, dirty, damp and mouldy in places. One wall had cracked plaster work and another wall had a large area of plaster board missing, exposing pipework within the wall.
● Maintenance issues presented health and safety risks. One bedroom door was propped open with a cupboard and a staff member told us the magnetic door release mechanism had not worked for a few months. We observed the door of the sensory room propped open with a chair. We identified a potential finger trap hazard on the staircase, where the banister almost touched a windowsill. One person's drawers had the top drawer removed, leaving the sharp metal drawer runner exposed.
● Bathrooms were in a poor state of repair. There were broken cupboards, one toilet had a broken seat and another had a broken flush button. We opened the cupboard drawer in one person's bathroom and found this had a dirty, cracked surface.
● We observed numerous uncovered radiators, some of which were very hot to the touch. One person was observed sitting on an uncovered radiator in the hallway, which was warm but not hot enough to cause a burn. However, there was a potential risk people could sustain burns.
● We were advised one person benefited from looking at lights on a sensory machine. This was not observed working throughout our inspection and information from the provider confirmed it was broken. We observed no similar sensory equipment available for the person's use. There was no evidence of how the rest of the environment had been designed to meet people's specific sensory needs such as lighting, sound and touch.
● We identified concerns regarding the safety and security of rear doors. The dining room door was secured with two simple bolts, one top and bottom, and a staff member explained the key to the lock had been missing for some time. The conservatory door was found locked, the door was heavily damaged, with part of the door having fallen off into the garden.
● The garden was not suitable for the purpose it was being used. A flower bed close to the back door contained brambles which were also found in other areas of the garden. The garden contained holes created by wild animals, and was generally uneven throughout which we were advised was due to moles.

We observed one person with mobility difficulties needed constant staff support and struggled to negotiate the uneven ground to kick a football. A staff member explained another person with visual impairment could not use the garden without holding onto staff as they could not see the mole hills.
● The maintenance book was poorly maintained. Several maintenance concerns had been logged by staff for the period of April 2020 onwards, however the columns to be completed with actions and completion dates had not been updated, meaning it was unclear how quickly maintenance issues were attended to.

The service was not always clean, well maintained or secure. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider shared an updated copy of the service's action plan during our inspection which showed maintenance jobs had been identified and progress was being monitored.

● The provider retained maintenance contractors to commence work. On our return visit of 5 May 2022 work had commenced to re-decorate the dining room. We observed the laundry room had been secured with a keypad lock, the conservatory door had been fitted with a thumb lock and was partially repaired, and additional window restrictors had been added. We were advised contractors had checked the temperature of radiators, although due to warm weather the radiators were off during our return visit.

Supporting people to live healthier lives, access healthcare services and support
● Care plans included an undated 'Health support plan', containing a list of diagnoses, prescribed medicines and allergies. There was no additional information within the health plans, such as the impact of diagnoses or the purpose of prescribed medicines. Some care plans contained information sheets, however information was not personalised. One person's information sheet about mood disorders described conditions including postpartum depression, seasonal affective disorder, psychotic depression and bi-polar.
● Each person using the service had a 'health passport' which can be shared when a person requires inpatient treatment. Health passports were partially completed and there was no evidence they had been regularly reviewed to ensure the information could be relied upon by health professionals. Some entries within health passports were last updated in 2017.
● One person's records contained an appointment letter for breast screening. A handwritten note stated, 'Appointment cancelled, best interest.' There was no information to explain how the decision was reached or whether a medical professional was involved in the decision. The person's care plan contained no information about any checks or visual observations required in the absence of breast screening to detect changes to the person's breasts.
● Records showed telemedicine, a digital healthcare system, hadn't been used since 29 January 2021. We were informed the password for the system was unknown. We reviewed an incident report, dated 9 March 2022, where a person was observed with red marks after a fall on the stairs. There was no evidence staff had sought medical advice or provided a rationale as to why this was not required. We reviewed the report for another person's fall from a chair, dated 22 June 2021. There was no evidence medical advice had been sought. The report stated the person was, "alright, had no injuries" but no detail was added to explain how the person, who communicated non-verbally, had been checked.
● There was no information about people's annual learning disability health checks in their care records. Some people had not accessed dental care or chiropody since prior to the pandemic. The service could not confirm when some people had last seen an optician. Although routine appointments were impacted by lockdown restrictions, the service had failed to provide timely support to resume appointments. A family member explained one person had last seen a dentist around two to three years ago and experienced bleeding due to gum disease. Staff confirmed they had noticed blood. The service could not confirm the date the person last saw a dentist, although a staff member advised this was prior to the pandemic. The

person's April 2022 teeth brushing record showed multiple gaps without explanation.
● Staff had not implemented guidance from the community learning disability team. A letter, dated 18 August 2021, asked staff to complete a sleep diary for two weeks due to concerns about a person's sleep pattern. There was no evidence of this being completed on file. There was no information in the person's care plans or risk assessments about how staff should promote sleep to improve wellbeing. During our night visit staff told us the person only slept for approximately three or four hours. Daily records for 14, 15 and 16 April 2022 showed the person slept for about five hours per night.
● The letter also stated staff should create a routine for supporting with continence pad changes as this caused the person anxiety. However, we found there was no information about a routine in the person's care plan. On one occasion we observed the person was wet at 10.05am and remained wet at 10.16am. At 10.28am we heard sounds of distress and observed the person had become agitated. After the incident we asked staff about potential triggers. A staff member explained the person had started to shout after staff tried to support the person to go the bathroom.

The service did not consistently support people to access healthcare services and support to meet their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual outlined actions the service was taking to ensure people could access healthcare. We were advised the service had requested GP summary records to obtain up-to-date information about people's previous contact with their GP. We were advised a mental capacity assessment and, if necessary, best interests process would be conducted in relation to the person's breast screening clinic letter. An appointment was booked for an optician to visit the service on 20 May 2022 and we were advised arrangements were being made for chiropody. We were advised messages had been left for dentists to check when people last received dental care.

● The service's action plan had identified the need to ensure people had access to a medicines review. An updated action plan indicated one person's medicines had been reviewed in March 2022 and medicines reviews for two people were booked for 26 April 2022.
● Some people were reviewed by a psychiatrist specialising in learning disability. We reviewed one person's recent psychiatry letter. The letter advised the person was reviewed on a six monthly basis and confirmed staff had provided feedback to assist their review.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.

● Records showed training in relation to MCA was in date for only four of 15 staff, and training in relation to DoLS was in date for five staff at the start of our inspection. Training for other staff was either incomplete or overdue refresher which the training matrix confirmed should be repeated yearly.
● At the start of our inspection no one using the service had an authorised DoLS in place and everyone was subject to restrictions due to potential risks. Records showed four people's DoLS authorisations had expired between March and April 2018. The service had failed to re-apply for DoLS authorisations until October 2018, meaning there had been a significant delay in applications.
● There was no evidence the service had sought verification where relatives indicated they held legal authority to assist with decision making. After our visit the nominated individual confirmed the service held no evidence of deputyship or power of attorney relating to two individuals and told us enquiries were being made to seek verification.
● People's records contained a form entitled 'Photography and video consent form' which ticked 'Yes' to the questions 'Can I take your photo?', 'Can I video you?' and 'Can I show it to other people?'. Care records contained photos of people partaking in activities. The questions were accompanied by a statement, "I enjoy when people take my photographs and enjoy looking at them too. Staff observed my reaction to photographs and has taken this view." The form did not evidence a MCA process had taken place, such as exploring whether people understood who would have access to their image.
● MCA records did not appropriately document how representatives were consulted. For example, an MCA assessment and best interest record dated 13 September 2021, for a decision to reside at the service, stated family input had been considered and they agreed but did not provide any specific information about their views. The assessment was only signed by the registered manager and deputy manager. The best interest documents for three other people with family involvement were also unsigned by families.
● Several MCA and best interests decisions were completed on 13 September 2021 involving six service users, covering topics from decisions to reside at Penley Grange, consent for COVID-19 testing, management of finances and consent for medicines. One person's best interests decision referred to a different person using the service. The MCA and best interest decisions for three female service users for COVID-19 testing, referred to them using male pronouns in the same four places using the same wording. One decision stated "[Person's] family are happy for [person's name] to have regular testing of the COVID-19", however the person had no family involvement. Our findings meant we were not assured assessments had been completed in accordance with legislation.
● Decision specific MCAs had not been recorded for additional restrictions, such as one person's recent use of a baby monitor, which had been used by night staff to listen for seizure activity.
● One person's MCA decision in relation to their finances had not been reviewed since 2019 and the MCA decision relating to their care and accommodation at Penley Grange had not been reviewed since 2020. Both MCA forms stated the decisions should be reviewed annually.

Effective systems were not operated to ensure the service worked in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an action plan in place. This had identified the need for mental capacity assessments where individual restrictions were in place. The action plan also monitored progress of DoLS applications.

● A document tracking DoLS applications and authorisations was in place. We were advised a DoLS assessor had recently visited to complete two assessments and the care consultant had recently submitted two DoLS applications. Following our site visit the local authority DoLS team confirmed DoLS authorisations had been

granted for two people and other DoLS applications had been allocated for assessment.

Staff support: induction, training, skills and experience

● Staff did not always receive appropriate training and ongoing support to benefit people using the service. We reviewed two staff training matrixes, one of which was recently developed by the care consultant. The matrixes showed numerous training gaps and expired training in topics such as moving and handling, person-centred care, first aid awareness and health and safety.

● Induction processes were reliant on e-learning to equip staff with knowledge and skills. We found the three newest staff members had not completed any e-learning. Another staff member employed since September 2021 had only completed one of twenty assigned e-learning modules. A staff member employed in December 2021 explained their induction had consisted of reading policies, procedures and care plans. They added they relied on direction from colleagues who they described as supportive. The staff member told us management changes had caused difficulties accessing e-learning and they were awaiting access. The nominated individual agreed to investigate to ensure the staff member was given access.

● Induction systems failed to assess whether staff demonstrated knowledge gained via e-learning. The induction records for one staff member employed since 2018 were only partially completed and they had not been signed off as competent. A supervision record dated January 2021 advised, "Explained about MCA, DOLS, confidentiality, examples given. [Staff name] have no understanding about these". We spoke with the staff member and found they lacked knowledge and understanding in areas such as safeguarding and equality and diversity.

● We found no evidence staff new to care had been supported to gain the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. The on-site care consultant confirmed they were not aware of any systems in place, explaining the Care Certificate was not included on the training matrix they had received.

● The provider's policy and procedure for physical interventions referred to a particular training course and technique, which was not provided by the service. Training records indicated six staff had previously received training entitled 'challenging behaviour' however at the start of our inspection, only two staff member's training remained in date.

● Staff training about specialist needs was inconsistent. The service had identified staff required training in bi-polar disorder and epilepsy. Records showed no staff had completed e-learning about bi-polar disorder and staff we spoke with had minimal knowledge about the condition. At the time of our inspection only two members of staff had up-to-date epilepsy training.

● A relative raised concern regarding staff training, advising "I don't think all of them have training, as it's mainly the temporary staff who are not using the best of actions or behaviours towards [relative], and you only make [relative] behaviour worse if you don't follow what you should do. Even the social worker said that strategies were not being followed, and that means training." Another relative commented, "I don't know [what training staff have received], but I observe a general lack with interactions, so there is a lack of understanding of complex needs."

● We were advised an agency induction process was in place, however the last written agency induction record accessible during our inspection visit was dated 26 September 2018.

● The agency induction form asked questions such as, "Have you given the agency worker a chance to read support plans?" The form did not assess their understanding of care plans or risks. An agency worker confirmed they had not read care plans and had been given a verbal handover. They were not aware of the diagnosis or the contents of the behaviour support plan for the person they supported. They advised, "Have been told, do what they do, sometimes they bribe with biscuit or will put music on." This was not in line with the person's behaviour plan.

● Staff supervisions had been completed at inconsistent and infrequent intervals by the previous registered manager and deputy manager. We found no evidence of staff appraisals. We could not locate supervision records for six members of staff and the on-site care consultant confirmed they had checked and had not been able to locate these records.

The service did not always ensure people were supported by suitably qualified, competent, skilled and experienced staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an action plan in place. This had identified the need for a staff training plan. The care consultant explained their intention was to hold a supervision meeting with each staff member to discuss their training needs. Supervisions with three staff had been held during April 2022 although at the time of our inspection there remained widespread training gaps.

● During our inspection the service identified dates for staff training in topics such as fire marshal training. The care consultant had provided some informal learning, such as working with staff to ensure they understood PPE guidance about the use of gloves.
● Records showed some supervisions had been carried out between January 2022 and March 2022 by the service's former operations manager. Staff had been asked for their understanding about topics such as mental capacity and whistleblowing. The operations manager had identified that training required completion, although numerous training gaps remained.

Requires Improvement

Is the service caring?

Our findings

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

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

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

● We found the level of interaction and engagement staff members provided to people was mixed. We observed an agency staff member supporting a person who was able to feed themselves. The agency staff held a biscuit between their fingers, and said to the person, "Open your mouth, open your mouth", and with a chuckle, they moved the biscuit away. Whilst we could not determine the agency staff's intention, the interaction did not promote the person's independence or treat them with respect, as we were advised the acting team leader had already broken the biscuit into small pieces to make it safe for the person to consume. The agency staff later used a loud tone, saying "sit down". During a meal three staff stood around the person's table, with the agency staff member leaning over the person during their meal. Staff interactions lacked warmth, such as using a frustrated tone to instruct the person, "Finish your food properly".

● During and after one mealtime we observed a person eating their lunch had food around their mouth. A staff member was sat next to the person watching, but did not offer any support to the person to wipe their mouth. On another occasion a person finished eating and walked around the dining room. A staff member approached them, and without interacting with the person, proceeded to wipe the person's mouth. This was not dignified or respectful.

● We observed occasions where staff did not respect people's privacy or seek their permission. A staff member provided CQC inspectors with a tour of the home, and proceeded to take inspectors into a person's bedroom without seeking consent. When an inspector prompted the staff member to seek the person's permission they looked surprised. When the inspector asked the person's permission, they smiled and quickly got up and led inspectors into their bedroom.

● One person had mental health support needs. We observed the person suddenly become upset and begin sobbing. The inspector looked to the staff member present who rolled their eyes and said, "He does this for attention." The staff member offered no reassurance or support either during the period the person was upset, or after they appeared a little happier. There was no attempt made by the staff member to find out what may have caused the person's distress.

● The person's records did not include a care plan for emotional wellbeing. A behaviour plan instructed staff, "not to react to the crying, offer [person] an activity of his choice." Staff told us, and we observed, the strategy used was to redirect the person to their bedroom when they became upset. On one occasion a staff member stood alongside the person trying to direct them to their bedroom. The person said "push me" which prompted the staff member to say they hadn't pushed them. Whilst we were satisfied abuse did not occur, the person's posture and refusal to move forwards, indicated they did not wish to be redirected. This

approach was not in line with the behaviour plan. Another staff member then attended and helped the person go outside in line with their choice.
● Incident forms and behaviour charts for the same person for February and March 2022 showed eight incidents where the person had cried. There was no evidence of management oversight to review potential triggers. Forms frequently stated the person cried without reason. One incident noted the person was, "Crying loudly and repeating 'I'm going', 'I'm going'" after a staff member had incorrectly told them they would see their family. The form noted staff had told the person they were going home without checking, which showed a lack of care for the person.
● A lack of window covering on one person's bedroom meant their privacy and dignity was not adequately protected. The window faced the front of the building and was partially missing a window covering throughout our inspection. The maintenance book confirmed the curtain pole had broken on 6 March 2022. The person was already known to experience poor sleep. We were concerned the service had failed to take timely action.
● CCTV cameras were mounted externally and in communal areas. The care consultant could not confirm the system had been switched off, explaining staff on-site could not access the system since the departure of the registered manager. The nominated individual confirmed the CCTV wasn't in current use. There was no impact assessment on people's privacy or evidence about how people were consulted before the CCTV had been made operational.
● Staff explained one person used another person's ensuite bath. We found boxes of the person's clothes were stored in the other person's bedroom, which a staff member stated was for ease of access. This practice did not respect either person's privacy.
● Care plans and risk assessments contained no information about the safe management of bedroom door keys to promote privacy. In relation to one person's bedroom, a staff member told us there had never been a key made available, meaning there was no opportunity for the person to lock their bedroom should they wish for privacy or to protect their belongings. We observed one person start to enter the person's bedroom before being redirected by staff. There was a known risk of this person causing distress to the individual.
● Staff training in relation to equality and diversity, and person-centred care, was either incomplete or overdue refresher for all staff.

The service did not always ensure people were treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual and care consultant provided feedback regarding planned actions to improve the culture of the service. We were advised actions would include staff training and a recruitment drive to identify candidates with suitable skills to provide quality care and support. We were advised CCTV cameras were switched off and an updated policy was available should the system be considered for use in the future. We were advised action would be taken to provide the person with a suitable window covering and to review arrangements for locks.

● We also observed positive interactions between some staff and people. We observed a staff member interacting with a person using the trampoline, throwing a large ball back and forth whilst they enjoyed bouncing. One staff member engaged with people in a friendly manner and with warmth. During a mealtime they joined in with a person's smiles, laughter and singing.
● One person using the service was observed partially undressed. A staff member promoted the person's dignity by encouraging them to return to their bedroom to select a different outfit.
● Staff described respecting a person's privacy who needed a longer than average period of time to use the bathroom. A staff member explained they would wait and speak to the person from their bedroom to ask if

they needed a bit longer. The staff member explained they would turn on the shower as a visual prompt, and wait for the person to get ready at their own pace.

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

● During our inspection we observed people were inconsistently supported with their preferred methods of communication to enable their involvement and seek their views. A relative commented, 'My feeling is that it's never been treated as a home for young people with a life ahead of them, but for older people.' We found no evidence people had been supported to identify goals or develop independence skills.

● Families provided mixed feedback about how the service had involved them in decisions about people's care. Families were satisfied they had been consulted about significant decisions, such as COVID-19 vaccination. However, records and feedback confirmed relatives had not always been informed when accidents and incidents occurred, which meant they were not involved in decisions about how the service responded to these. Relatives indicated they had started to receive notification of incidents, however this was inconsistent, because incidents were not consistently documented.

● A night care worker told us, and we observed, people were supported to get ready for bed by 9.30pm. The night worker explained they carried out regular checks throughout the night, which included putting the light on to check people's faces to see if they were asleep. We asked if there was an offer of activities where people were awake during the night shift. The staff member responded, "Night is not [for] activity, night is for sleep." Care plans did not evidence that people had been supported to make choices about what time they went to bed or how they wished to spend their evening.

● Care plans did not routinely specify whether people had a preference for staff gender. Staff advised one person was only supported by female staff, however this was not referenced in their care plan. Another female person was supported by male staff for personal care, on occasions when only one female staff member was on duty. Staff told us the person was comfortable with male support, however their care plan did not provide guidance about staff gender and the person was unable to express themselves verbally. One person's care plan did refer to staff gender following a previous concern about their behaviour.

The service failed to consistently involve people and their representatives in decisions about their care. This was a breach of Regulation 9 (Person-centred care) of the health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The service had an action plan in place. An initial meeting had been held with people's families following the arrival of a care consultancy. We were advised all care plans, risk assessments and activity plans would be reviewed and re-written in consultation with people's families. The care consultant explained they were in the process of contacting all families.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care plans were task focused and did not reflect a holistic picture of people's needs and preferences. Care plans and monthly keyworker reviews did not contain information about people's future aspirations. There was no evidence people were supported to learn new skills.
- People were not supported to engage in a variety of external activities. The service failed to re-establish varied activities after national COVID-19 restrictions ended. One person attended a day centre. Other external activities offered were trips to local parks and takeaway lunches. A staff member told us for two people other activities were "not possible" due to concerns people may touch members of the public or grab their food. Another staff member expressed similar concerns. We were concerned staff confidence and skills in supporting people's behaviours had limited opportunities for external activities.
- Limited on-site activities were observed in use, such as colouring, puzzles, watching TV, throwing a ball and use of a trampoline. Whilst some people were observed to enjoy these activities, they did not offer opportunities to try new experiences. For example, during several visits a person was repeatedly offered two tubs containing a mixture of puzzle pieces, crayons and blunt pencils. Although the person enjoyed colouring, we did not consistently observe staff offering or encouraging a greater variety of indoor activities.
- Some people had undated activity plans kept in the staff office. We did not observe staff referring to the activity plans. A staff member explained the management of the service had recently created the documents. It was unclear whether people had contributed to their activity plans and some of the suggested activities were vague, such as 'home activities' or contained insufficient activities for a meaningfully structured day.
- For example, one person's activity plan contained one or two activities in the morning and afternoon such as hoovering, baking, arts and crafts, picnic, drive, walk, and 'home activities'. The person was only able to engage in activities for brief periods. This meant with only one or two options on the activity plan there was a lot of time where there was nothing for the person to meaningfully engage with. We observed staff encouraging the person to sit in the lounge. The person did not appear to engage with the TV, which was showing children's programmes.
- Staff told us they needed more resources to promote meaningful activities. A staff member commented, "[It] would be nice to have…more activities and opportunities for residents and resources…not loads here to try [with people]."
- One person did not have an activity plan at the start of our inspection. Their care plan noted they enjoyed shopping. Financial records showed between 5 February 2022 and 26 April 2022 the person only had £3.35 personal spending money and there was no record of personal spending for this period. A staff member

expressed concern and told us the person had enjoyed shopping, and they wanted to help the person shop for shoes, clothes and a handbag. The provider explained the authority responsible for the person's finances had agreed an allowance of £50 per month in December 2021. £100 was added to the person's spending account on 27 April 2021.
● Staff did not consistently promote people's independence. One person's speech and language therapy report stated, "[Person] can feed herself and should be encouraged to do so as much as possible prior to staff intervening." A staff member confirmed at times the person could feed themselves. On one occasion we observed a staff member immediately start to feed the person by holding a spoon to their mouth, without any attempts to encourage independence.

The service did not provide personalised care and support to meet people's holistic needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we received an updated action plan which confirmed personalised activity plans would be developed. The nominated individual explained families had been approached for feedback. On 6 May 2022 we received copies of proposed activity plans. The activity plans indicated a greater variety of external activities would be offered.

● We observed examples of positive engagement in activities. One person enjoyed playing with a ball. We observed a staff member playing catch with the person over an extended period of time. The person communicated non-verbally and their facial expressions and vocalised sounds indicated they were engaged and enjoying the activity.
● People were supported to maintain relationships with their family members. Some people regularly stayed overnight with their families. The service had explored the use of remote video calls to help people stay in contact with close family members during the pandemic.
● One person had developed a friendship with a person living at the adjoined care home. On 27 April 2022 a staff member told us they had been advised the person was "not allowed" to go next door and would try to bring them back. Another staff member told us the person "quite often quickly runs next door" adding "when weather nice have sat over with friend." On the last day of our inspection on 5 May 2022 we observed the person spent a period of time visiting their friend and were supported to do so by a staff member. The nominated individual told us the service would explore further opportunities for planned joint external activities to further support the friendship.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The service was not fully compliant with the Accessible Information Standard. Some care plans referred to the use of communication tools or techniques such as Makaton (a type of sign language) to help people understand information and communicate. We found staff use of these methods was inconsistent. Training records confirmed staff had not received communication training. There was a reliance on people's understanding of verbal communication where people may also have benefited from engagement using their other identified communication methods.
● One person using the service required spectacles. When viewing the person's bedroom we located their

spectacles in a drawer. A staff member confirmed staff had not provided the spectacles that morning. They took the spectacles to the person to wear.

● One person used Makaton and pictorial cards. Our observations and staff feedback confirmed these communication methods were inconsistently used. Two staff members supporting the person confirmed they did not know how to use Makaton signs. Another staff member confirmed communication with the person was more effective using Makaton, advising, "She knows Makaton, when [I] do it she's watching and…looks like she's understanding what [I'm] doing…[visual aids] could be used more consistently."

● A staff member explained the person's pictorial cards had been lost, commenting, "Used to [use with person] such as encourage out for drive, at some point lost it, start to work without…if new member of staff come…can be difficult…as [person] doesn't listen…haven't been using for a while." We observed a staff member using some loose picture symbols; they explained the strip used with the cards to show 'now and next' had been lost. On the last day of our inspection a grouped set of communication cards had been located and given to an agency staff member, although we observed brief verbal interactions and later the cards were left on a table when the person moved to another location.

● Another person's care plan stated they used Makaton and visual aids such as pictorial symbols, now and next cards and picture menus. We did not observe visual aids used during our inspection, with the exception of one occasion when an agency staff briefly showed the person a set of communication cards, although we observed the cards were used as a form of distraction rather than for the purpose of communication.

● The same person was not consistently supported by Makaton trained staff. An agency staff member providing care confirmed they could not use Makaton. We observed limited interaction, focused on giving instructions. On another occasion the person responded to Makaton, using a hand sign and smiling. This was an isolated observation, in contrast to other interactions where staff relied on verbal communication to which the person didn't consistently respond. A staff member told us the person enjoyed using Makaton when the staff member we had observed was on shift, which indicated at other times their communication needs were not fully met.

The service did not ensure people received personalised support to meet their communication needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acknowledged action was required to address the concerns identified in relation to meeting people's communication needs. We were advised the service planned to re-introduce communication books to provide staff with more information about people's communication needs, including prompts for Makaton. The service also told us staff would receive communication training.

● We observed one member of staff proactively using Makaton with two people who responded positively. They told us for one person who could not communicate verbally they were trialling the use of hand signals for yes and no to explore whether this could help the person communicate, advising, "Have tried to do few times with [person], sometimes think almost coming along, other times think wasn't [understanding]… persevering with [person]."

Improving care quality in response to complaints or concerns

● We reviewed the service's compliments and complaints file. The policy accessible to staff within the file was effective October 2011, review date October 2014. The policy was not appropriate because it did not provide information about the local government social care ombudsman (LGSCO) and the contact details listed for the provider were incorrect. A list of useful contacts included the LGSCO, however the policy did not explain that complaints could be escalated to the LGSCO.

● The service's complaints and compliments register was last updated in December 2016. The service had

logged a mixture of compliments and complaints during the period of 2015-2016. It therefore appeared unlikely the service had not received a single compliment or complaint for the period 2017-2022. A selection of Christmas cards inside the folder included a compliment from 2019. Therefore we were not assured the complaints and compliments register had been appropriately maintained.
● We received variable feedback from relatives about whether concerns and complaints had been handled and responded to effectively. Comments included, "The concerns mainly I've sent emails about, and earlier on I had responses, but the manager was overwhelmed" and "I would complain and have done in the past, and things got resolved by the manager sometimes."
● Care files contained an easy-read document advising they could complain verbally or via telephone, email or post. The easy-read documents had not been personalised for individuals, for example, some people with very limited verbal communication may have benefited from a document containing less text and greater use of images which were meaningful to them.
● Minutes of resident meetings showed these had been used to remind people about how to complain, however a resident meeting had not been documented since June 2021. The monthly keyworker review template did not include a section about feedback from people, meaning it was unclear how the service gathered and responded to feedback, concerns or complaints.

Systems were not operated effectively for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection the provider had purchased a new suite of policies which were due to be implemented. This included a new complaints, suggestions and compliments policy which provided clear guidance about the role of the LGSCO.
● The care consultant confirmed they had not received any formal complaints since their recent arrival at the service.

End of life care and support
● During our inspection the service was not supporting anyone receiving end of life care. Some people living at the service were younger adults.
● Care plans did not contain information about people's end of life wishes and preferences.
● One person's deprivation of liberty safeguards (DoLS) authorisation dated 4 April 2017 had noted the absence of an end of life care plan and included a recommendation from their advocate, "IMCA [advocate]…has recommended for a 'When I die plan' to be put in place and for Penley Grange management to be encouraged to consider this." We found no evidence this recommendation was acted upon.
● A training course entitled "End of life planning" was identified on the service's training matrix, however the matrix confirmed staff had not completed this training.

We recommend the service ensures people are supported to make decisions about their preferences for end of life care and to ensure staff are aware of national best practice guidance and professional guidelines for end of life care.

● The provider had purchased a suite of policies which were due to be implemented. These included an end of life care planning policy which referred to national best practice guidance.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● A registered manager had been responsible for the service and an adjoined care home operated by the same provider. A CQC inspection of the adjoined care home in February 2022 identified significant concerns. The provider took the decision to suspend the registered manager due to concerns about their performance. The registered manager also submitted their resignation. This meant there was no registered manager at the time of our inspection.

● Prior to our inspection we received information of concern, alleging there was a poor culture and that the registered manager failed to provide recently recruited managers with access to documentation. The director had informed CQC they were aware the registered manager had been difficult to work with. Although we were informed the director regularly met with the registered manager, no supervisions, appraisals or development meetings were documented.

● The service was supported by an on-site care consultant. We could not be assured the consultant had up-to-date knowledge to enable them to identify and effectively address concerns with staff practice. The consultant provided open feedback that although they had transferrable skills from their background as a specialist nurse, it had been "a lot of years" since they had worked with a learning disability service. In relation to training for responding to people's behaviours they stated, "any training I've had [is] years out of date", but confirmed they had previously received training in techniques to respond to physically distressed behaviours, such as the use of break-away techniques. One person experienced periods of agitation. The consultant commented, "I don't know how to deal with him…[I] would like to go on the training if it's available." The consultant explained they planned to seek guidance from the professional who had written the person's positive behaviour support plan to help develop their knowledge of the person and how staff could effectively support their behaviours.

● The sole acting team leader had not received training for their role, pending the recruitment of team leaders. We were concerned about the sustainability of this arrangement, on one occasion observing the acting team leader trying to split their time between supporting people, conducting handover, responding to staff rota queries, attending a GP surgery to sort a prescription, administering medicines, preparing food, and assisting the adjoined care home. We were advised the staff member had been informally appointed by a previous manager and a formal recruitment process was underway for permanent team leaders. On another occasion in discussion with the care consultant on 19 April 2022 it became evident they were not aware who was on duty or the plan for the day, such as staff ratios for a trip out. There was a lack of oversight to ensure people's and staff safety.

● The registered manager had not followed correct records management procedures; records were poorly

maintained or inaccessible. We located confidential paperwork in an unlocked kitchen drawer. The office was insecure because staff left the key in an unlocked key-safe. Some records did not appear to have been reviewed or updated since 2017. We were concerned the provider's monitoring had failed to address the deficiencies with records.

● Supervision records were absent or poorly documented by the registered manager. A supervision record dated 1 February 2021 stated, "Deputy/good/privately. Missing money. Had phone money." There was no explanation as to what this referred to. Where staff had raised concerns during supervision, it was sometimes unclear what actions had been taken. A supervision record dated 17 August 2021 stated, "Atmosphere used to be enjoyable…atmosphere like school…nagging, not children." No explanation or actions were noted.

● People's care records were not always accurate or contemporaneous. A night staff member told us when day staff were too busy, they would write handover records the following day. They advised rather than documenting their regular checks during the shift, they retrospectively documented all checks after 5am. We also identified numerous gaps in records for people's bowel movements, teeth brushing and bath and shower temperatures without explanation. Care files frequently contained no references to reviews of risk assessments or behaviour support plans to evaluate whether these were appropriate or effective in preventing and reducing risks.

Governance systems did not effectively assess, monitor or improve the service. The service failed to securely maintain accurate, complete and detailed records in respect of each person using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place which was updated during our inspection with additional actions that had been identified to improve governance. A care consultancy was supporting the service to implement the action plan and recruit a new manager. Following our initial visits to the service we were aware another consultant had also spent time on-site to support with the development of activity plans and care plans.

● The provider had reviewed management structures. Recruitment was underway to fill vacancies for the proposed service structure and to reduce reliance on agency staff. The NI explained in addition to a new manager, the service planned to recruit team leaders and staff for newly created 'care buddy' roles, to provide quality one to one care to people.

● Some staff provided positive feedback regarding the care consultant. A staff member commented, "[Consultant] has been brilliant, has been really approachable." Some staff indicated they had not noticed many changes, but there were examples given of positive changes. A staff member explained it was easier to access a weekly food shop and explained families had been contacted to purchase new clothes for people where this was needed.

● In addition to the consultant we met on-site, other consultants were identified to offer support based on their areas of skill. For example, during the inspection period we were made aware a different consultant was working on-site to develop activity plans.

Continuous learning and improving care

● Systems were not established or robust enough to effectively assess, monitor and improve the safety and quality of the service. Prior to the recent arrival of a care consultancy, there was limited evidence of oversight or auditing by the provider. We located an infection control and kitchen health and safety audit, dated January 2022, completed by an operations manager. These audits had failed to identify and address concerns we found, such as gaps in staff training for infection control and food hygiene.

● Where audits had taken place these were often undertaken at inconsistent intervals, had failed to identify known concerns or actions had not been taken to rectify the issues identified. We found the kitchen and office first aid boxes contained a total of one plaster, which was not of a colour detectable for food handlers. The monthly first aid box audit for February and March 2022 stated "Need to order" but records indicated the last items were ordered in January 2022.
● Governance systems were not operated effectively to reduce the risk of financial abuse. We checked three people's personal money tins and found balances did not match the expected balances. Audits had not been conducted monthly in line with the provider's policy. Two people's records each contained two McDonalds receipts dated 11 November 2021. The corresponding audits were 'ticked' to confirm no errors were found and there was no scrutiny of the receipts. In relation to one person the nominated individual confirmed staff had eaten the extra meal, stating previously staff had been advised they could purchase a small meal or drink for themselves weekly from the person, describing this as, "common practice…in this client group", adding "we have asked staff to refrain from this practice at this time whilst we review." The director confirmed money for staff meals should instead have been taken from petty cash, rather than people's personal funds and it was stated a misunderstanding had occurred. We submitted a safeguarding referral and the service confirmed they would audit records and started to reimburse people after our inspection. We were advised payments had included an additional financial goodwill gesture to affected people.
● The provider had not ensured policies and procedures were reviewed in response to learning from audits or changes to best practice guidance. For example, the provider's 'Recruitment of personnel' policy, which was undated, referred to the CRB system for criminal records checks, which had been replaced with the Disclosure and Barring Service in December 2012.
● Prior to our inspection an incident occurred where a night staff member was observed with their eyes closed. We were advised the staff member had been spoken with. On 28 March 2022 the nominated individual (NI) stated, "Additional spot checks are in place to mitigate the risks of recurrence." We found limited evidence of spot checks. Evidence from the NI confirmed a care consultant had been on-site overnight on 8 May 2022 to work on a care plan, but there were no details documented of how staff performance was monitored. We were also advised, "Although the provider completed some night spot checks, she did not formally record these. No manager night checks could be located."

Governance systems did not effectively assess, monitor or improve the service. The service did not consistently mitigate any risks relating the health, safety and welfare of people using services and others. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place. Prior to our inspection the provider had engaged a care consultancy to provide on-site and off-site support. This included the appointment of a nominated individual (NI) from the consultancy to support the director, who was the former NI.

● The care consultancy had created an action plan, which was updated during our inspection. This identified actions such as re-writing care plans and risk assessments, and work to address environmental concerns. On our final visit we observed some of the environmental concerns had been addressed, such as securing the laundry with a keypad lock. Whilst we could not observe meaningful impact in relation to how people were supported by staff, including the range of activities offered, work was continuing. We received copies of draft activity plans which we were advised would be shared with families for feedback.

● The service failed to comply with the requirement to notify CQC of incidents that affected the health, safety and welfare of people using the service. Prior to April 2022 the service had last submitted a statutory

notification in December 2019. Concerns that met the criteria for allegations of abuse were not reported.
● Following the departure of the registered manager, a care consultant had reported some new incidents to CQC, however, the service had failed to submit notifications for all recent safeguarding concerns and incidents they had been made aware of.

The service failed to notify CQC about incidents as required. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Engagement with families had been inconsistent. Prior to one recent meeting with relatives, we found no evidence surveys or meetings were facilitated to gather views about the running of the service. Some families indicated they were previously involved in annual care reviews although care plans were often undated, meaning it was unclear when they were last updated in response to feedback.
● Family comments in relation to communication included, "The previous manager wasn't good at responding to emails. Communication on her part wasn't great" and "I'd go to the manager, although I don't know who the manager is, and that is one of my issues…it's the communication…they don't tell you who they are when they answer the phone."
● People were not meaningfully engaged and involved in the running of the service. Records showed resident meetings had been held between January 2021 and June 2021. Whilst meeting minutes provided some evidence people were consulted about the food menu or upcoming events such as Mother's Day, meetings was generally repetitive, with each meeting repeating topics such as social distancing, handwashing and the fire evacuation process.
● Prior to the recent arrival of a care consultancy, there was limited evidence the provider had taken steps to address longstanding risks the service presented of a closed culture. A closed culture can be described as a poor culture that can lead to harm. There were multiple potential warning indicators, including failures to identify safeguarding concerns, lack of suitable induction, training and supervision of staff, high use of agency staff, care plans not reflecting the person's voice and communication plans not being followed. Whilst we noted the provider had recently appointed an operations manager, we could not identify their input as having brought about meaningful change before they were suspended on 23 March 2022. They resigned and left the service.
● Staff meeting minutes dated 27 July 2021 described a poor culture. Minutes included, "Discussed [regarding] the staff attitudes, behaviours on the floor in front of residents. Residents have been copying what the staff are saying on the floor. All staff problems, fights, arguments must be left outside the building…Staff must maintain resident's privacy and dignity. If there is a resident having personal care or using the bathroom, another resident must not be taken to the same bathroom for change or use the toilet." There were no actions added to indicate how the manager intended to monitor staff culture.
● We received mixed feedback from staff. The consistent message from staff was a desire for management continuity and access to more resources to enhance activities for people. One staff member provided positive feedback regarding the former registered manager, stating they had worked with her for a number of years and had no concerns. Another staff member stated when the registered manager hadn't been on-site they were easily contactable.
● However, some staff told us the registered manager had failed to act to fully address their concerns, such as ongoing concerns regarding one person's behaviour. Although regular staff meetings were held, a staff member advised staff had become frustrated. They explained at first the registered manager "actually was listening", however described this had changed. In relation to staff meetings they commented, "Most [of the] time meetings [were] always the same, same things, no solutions."

● Not all staff were treated fairly. We were advised by the nominated individual that "cultural" attitudes amongst some staff meant there was an expectation females would complete domestic tasks. Two staff raised concerns regarding two managers who had recently resigned and left the service. A staff member alleged when performance issues had been raised by the managers, this had been done in a manner which caused them distress.
● Records and feedback indicated health and social care professionals had sometimes been involved in people's care. For example, recent social care reviews had been carried out and some people had regular reviews with a psychiatrist. However, the service did not consistently implement professional guidance to achieve good outcomes for people. For example, we found no evidence staff had followed guidance in relation to one person's dental care and their care plan had not been updated to explain how two different toothpastes should be used.

Systems were not consistently operated to seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders to continually evaluate the service and drive improvement. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place and had placed a priority on improving engagement with people's families. The provider acknowledged improvements were required to the culture of the service; they told us a staff meeting and staff training was planned alongside recruitment to identify suitable staff. The provider was invited to regular meetings with the local authority to discuss concerns raised via monitoring visits and discuss progress of the action plan.

● The provider held a meeting with people's relatives on 22 March 2022. This provided open feedback to families, explaining concerns had been identified and improvement would be required across the organisation.
● Some families indicated communication had started to improve since the arrival of a care consultancy. A relative explained, "Overall communication could be improved and [consultancy name] have it on their action plan…I've had calls…with the previous manager I never got a call at all…the new management is temporary…I'm in communication with [consultant name] during the week, and [consultant name] the weekend manager. I can contact either."
● Supervisions carried out during 2022 had provided staff with the opportunity to give feedback. One staff member told us their feedback had been acted upon when they suggested a few items they wanted to order to support activities. They added supervision had been helpful, advising, "Gave opportunity to say what [I] thought, if there was anything I'd like to see change."

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
● Accidents and incidents had not been adequately monitored to identify potential notifiable safety incidents. At the time of our inspection we did not identify any recent notifiable safety incidents based on incident records we reviewed.
● We identified indicators of a closed culture at the service. There was no evidence the previous registered manager had provided information, and where relevant an apology, to people or their representatives when accidents or incidents had occurred.
● Relatives comments included, "We wouldn't know if there were any [incidents]" and "I have been informed in the past, but it's probably been awhile, about 18 months ago they said she had a fall or something."

We recommend the service reviews their approach to ensure duty of candour responsibilities are met.

The provider had an action plan in place. The provider had purchased a new suite of policies and we were provided with the new duty of candour policy which was due to be implemented.

● Relatives confirmed the care consultant had started to provide information about accidents and incidents. A relative commented, "There has been an incident reported, only since the consultancy firm has been in…they let me know."

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 service failed to notify CQC about incidents as required

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems were not operated effectively for identifying, receiving, recording, handling and responding to complaints.

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 9 HSCA RA Regulations 2014 Person-centred care The service did not ensure that care plans fully identified or met people's needs. The service failed to consistently involve people and their representatives in decisions about their care. The service did not provide personalised care and support to meet people's holistic needs, including their communication needs.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not always ensure people were treated with dignity and respect.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Effective systems were not operated to ensure the service worked in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established or operated effectively to assess, monitor and mitigate risks to

the health, safety and welfare of people using the service. The service had not ensured the proper and safe management of medicines. The service had not established or implemented robust infection prevention and control procedures to effectively mitigate risk to people.

The enforcement action we took:

We imposed a condition on the provider's registration.

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 were not established and operated effectively to prevent abuse of service users or to investigate concerns.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not consistently identify or meet people's nutrition or hydration needs.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service did not ensure that care plans fully identified or met people's needs.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems did not effectively assess, monitor or improve the service. The service did not consistently mitigate any risks relating the health, safety and welfare of people using services and others. The service failed to securely maintain accurate, complete and detailed records in

respect of each person using the service. Systems were not consistently operated to seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders to continually evaluate the service and drive improvement.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We were not assured enough suitably qualified, competent and experienced staff were deployed to safely meet people's needs.

The enforcement action we took:

We imposed a condition on the provider's registration.