Parkcare Homes (No.2) Limited

Tithe Barn

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Tithe Barn is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Tithe Barn provides accommodation and personal care for up to thirteen adults who have learning difficulties and may also autism and/or have behaviour that may challenge. Some people had sensory impairments, epilepsy, limited mobility and difficulties communicating.

The home is split up into five shared flats.

The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. There was a risk the size of the service had a negative impact on people.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, independence and inclusion. The outcomes for people at Tithe Barn did not reflect the principles and values of Registering the Right Support. 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 interest. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them. People with learning disabilities and autism living at Tithe Barn were not supported to live as ordinary a life as any citizen.

People's experience of using this service
The management and staff had not supported an empowering, inclusive culture.

People were not treated with dignity and respect. The language and actions of some staff was disrespectful and at times allegedly abusive. The local authority safeguarding team were investigating, and the investigations have not yet been concluded.

People were not always safeguarded from abuse and improper treatment. The registered persons failed to consistently ensure people were protected from avoidable and intentional harm. Some incidents had not been reported to local authority safeguarding team when they should have been. Individual risks to people had not been fully identified and mitigated.

People were not being supported to be as independent as they could be with their daily activities. There was lack of choice and people were controlled by staff. People were told what they could do and when they could do it. The kitchen doors in the flats were locked so people who were able to with staff support could not freely help themselves to drinks and snacks. People said if they wanted drinks or snacks outside meal

and drink times they had to ask permissions from the staff. Apart from one person, people were not supported to choose what they wanted to eat and were not able to choose the activities they wanted to do. These decisions were made by staff.

People's health needs, such as constipation and epilepsy, were not always being met effectively. When people's fluid intake was monitored this was not accurately recorded to make sure they were drinking enough. People did not always receive personalised care. Some people's communication needs were not met in a personalised way.

Medicines were not managed as safely as they should be. Medicines delivered to the home had not been booked in correctly. Medication temperatures were not consistently monitored. Medication keys were not kept secure. People's 'when required/'PRN medication protocols were not giving staff clear instructions as to when they should be administered.

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Some of the staff working with people did not have suitable skills, understanding and values to work with people. These concerns had been identified at staff meetings, but no action was taken by the registered persons. Staff continued to work with people in a controlling, disrespectful and restrictive ways.

Staff told us that they had made complaints to the registered manager about the way people and they were being treated but their concerns had not been taken seriously and no action had been taken.

Action was not taken to learn lessons and improve the service people received when things went wrong.

People were not involved in planning their care and support in the way they would have preferred.

The governance arrangements including the checks and audits had not picked up the range of issues found at the inspection. The culture of staff being in control had not been identified and addressed, so it continued. The home environment was not always clean, and measures were not in place to prevent the spread of infection.

There was a lack of oversight and scrutiny by the registered provider and senior management. This had led to unsafe risks and care for the people living at Tithe Barn. Systems for checking and improving the quality of care and support people received did not identify concerns and affect change. Concerns relating to keeping people safe, protecting them from abuse, minimising restrictions upon people, the staff culture and oversight of the care and support people received to stay safe, had not been recognised, identified and improvements had not been made.

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

The last rating for this service was Good (The last inspection report was published on 17 January 2019).

Why we inspected
The inspection was prompted due to whistle blowing concerns received about the restrictive and controlling culture of the staff. A decision was made for us to inspect and examine those risks.

The provider has taken action to mitigate the risks and we are monitoring the service to ensure the action the provider is taking is effective.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to failing to protect people from avoidable harm, failing to effectively risk assess, failing effectively monitor the service, failing to safeguard people, failing to provide person centred care, failing to ensure competent and trained staff were deployed at this inspection, failure to supervise and monitor staff and failing to submit statutory notifications to CQC.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

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

Is the service caring?

Inadequate

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

Is the service responsive?

Inadequate

The service was not responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our Well-Led findings below.

Tithe Barn

Detailed findings

Background to this inspection

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

Inspection team: The inspection team consisted of two inspectors on the first four days of the inspection. On the 27 September 2019 a fifth inspection day was completed by one inspector and a Specialist Advisor who was a Pharmacist.

Service and service type
Tithe Barn is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager 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. However during the inspection the registered manager decided to resign from their post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information of concern we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We also sought feedback from the local authority and professionals who work with the service.

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

and made the judgements in this report.

During the inspection-
We spent time with people in their flats to experience what it was like to live at Tithe Barn, because people living there had communication difficulties and were unable verbally express their views.

We spoke with 13 members of staff including the managing director, operations director, quality director, registered manager from another of the provider's home, two of the deputy managers, senior support workers, and support workers. We reviewed at a range of records. This included seven people's care records and multiple medicine records. We looked at a variety of records relating to the management of the service, including eight staff files in relation to recruitment and staff supervision. We also looked at accident and incident records, staff meetings and the staff communication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with partner agencies and professionals including the local safeguarding adults' team. We sought more information from the provider including training records, medicine records, the staff rota and audits of the service.

Inadequate

Is the service safe?

Our findings

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

At 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 in harm.

Systems and processes to safeguard people from the risk of abuse

● Prior to our inspection we had received concerns regarding aspects of the care and treatment of people who lived in the home. We made the provider aware of our findings and at the time of our inspection these allegations were subject to both external [police] and internal [provider] investigations. Although the provider had a safeguarding policy in place, staff we spoke with had not always reported their concerns to protect people and keep them safe.

● Since our inspection the provider has ensured the safeguarding concerns have been reported to the local authority and the Care Quality Commission have received the required notifications. However, the actions were taken because of our inspection findings and not through the providers own course of action.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

Using medicines safely

Medicines management within the home was not safe putting people at unnecessary risk.

● Medicine temperatures were not always recorded. We saw the temperature of the medicines stored had exceeded the recommended range of 28 degrees, but no action had been taken. Medication should be stored between 15 and 25 degrees. If not stored properly medicines may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. This had not been identified by the management or staff's medicine checks or advice from the pharmacy sought.

● We found the printing on the medication administration record [MAR chart] was illegible, so staff could not be sure what medicines they were dispensing. Although a deputy manager was aware there was no documentation to show this was proactively being followed through with the pharmacy. We reported this to the operations manager who told us action would be taken to rectify the situation and new MAR sheets would be requested from the pharmacy.

● We found the amount of medicines being stored did not always correctly match the amount on the MAR chart. The amount of medicines carried forward had not been recorded so it was not possible for the deputy manager to accurately check the medicines, so they could assure themselves people had their medicine as. prescribed.

● We raised our concerns immediately with senior management who told us a medicine audit would be undertaken. However, when we returned to the home on the 27th September 2019 we found further concerns with the administration and management of medication. In the last seven days there had been three separate medication errors. One person had received another person's medication and four people had not received their medication on one occasion. Another person had been given 'when required' [PRN] medication which was not recorded on the [MAR chart] or administered, the reason it should be according

to the PRN protocol.
● We also shared our concerns over the medication keys not being stored securely. This meant any staff or could access the medicines.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. Following this inspection, we passed our concerns about people's safety to the local authority commissioners.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong
● Risks to people's safety were not always assessed, mitigated or managed. Staff did not always follow risk guidelines for example, a visiting social care professional alerted the inspection team to a concern about a person's safety. The person's care records documented staff should always know the whereabouts of the person due to their lack of personal and road safety awareness. However, when the social care worker discussed this with staff about the persons whereabouts they were told staff did not know where the person was. Staff were not following the person's care plan so putting the person at unnecessary risk of harm. We found this was also the case during our inspection visits when at different times staff did not know where the person was to show risks to the person were being mitigated.

● Staff members told us accidents and incidents were not always reported and recorded. They were able to give the inspection team details of incidents and when we checked the incident records no paperwork could be found.

● There was little evidence of learning from events or actions taken to improve the safety of people living at the home and the staff team. There was limited use of systems to record and report safety concerns, near misses, accidents or incidents. Where people had been involved in physical or verbal altercations or had presented with behaviour that challenged, these weren't always investigated. This meant the root cause of the incidents to show the reasons for these happening were not analysed to highlight what steps could be taken to prevent the same thing happening again.

Staffing and recruitment
● The provider's recruitment processes did not always ensure the suitability of potential staff to care for people.
● Staff told us that prior to commencing in post, they were required to submit two references and a Disclosure and Barring [DBS] check. The DBS check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed.
● We found the registered manager had identified information of concern about a potential employee through their recruitment checks. The registered manager and senior management team had failed to assess the risk relating to this information and the individual supporting vulnerable people before they started work. This meant they had failed to take any steps to manage the potential risk and they put people at the unnecessary risk of avoidable harm.
● Some staff told us there were not always enough staff working on shift to care for people safely. For example, we heard about an incident which had occurred in one part of the home, when a staff member was left working on their own where we were told by staff members there should have been two staff members present at all times. This meant staffing arrangements had not been reviewed in response to ensure people's needs were met and the risk of avoidable harm was reduced.

Preventing and controlling infection

● Although the provider had policies and procedures to ensure the home environment was clean and hygienic, they had not done all that was reasonably practical to reduce risks of infections spreading. For example, we identified mould in one bathroom and people's individual towels were left on top of each other in communal bathrooms which posed a risk of cross infections.

● We found used mops and buckets left unattended around the flats for example, in one lounge and on the landing area

● In one flat we found the kitchen worktop was in a need of replacement. In the food store we found the tiles, flooring and fridge to be unclean. In addition, some food items were out of date. The operations director acknowledged the concerns we identified and took action for this room to be cleaned.

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.

Staff support: induction, training, skills and experience

● Staff we spoke with told us the training they had received did not always equip them with the skills they needed to do their job effectively. One staff member told us, "We could do with some training in mental health, as a lot of people living here have mental health difficulties. I have asked for it but as, yet it has not happened."

● Not all staff administering medication had been trained in the new system of medication management that had been introduced. One member of staff told us, "I don't feel competent giving medication, I've told management, but I am still expected to give it." This meant the registered manager and the provider had not ensured staff medicine practices were assessed and effectively met the needs of people who lived at the home so risks to people from avoidable harm had been mitigated. When we spoke with the operations manager they told us there had been a change in the way medicines were dispensed from the pharmacy. They were now in individual boxes rather than blister packs. Not all staff had received the training, so were not confident in administering medication. They told us they would ensure staff were given extra training and support.

● Although staff told us they had received specialist training in positive approaches to support people with their behaviour that may challenge. Staff told us the training received was not always tailored to the individual needs of the people they supported, so was not always effective. We were given examples where staff and the people they supported were left in vulnerable situations. For example, one staff member was left with three people in a flat and was physically assaulted, it was only when another staff member happened to hear their call for help and came to their assistance. According to the providers guidelines there should have been two staff present in order to maintain people's and staff's safety.

● Incidents reported identified there were not always the contracted staffing hours provided for people and put both people and staff at risk of harm. The deployment of staff across the home did not always mitigate the risks to people's safety and welfare.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing.

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

● People's needs were assessed prior to moving in to the service. The pre-assessment process ensured a care plan detailed guidance for staff on how to meet people's needs. However, the pre-assessment did not

consider the personalities and the combined needs of people supported, and their compatibility. Staff described how one person's behaviour had changed because a new person had moved into their flat whilst they were away on holiday. They told us the person no longer spent time in their flat as they used to.

● Staff told us one person living at the home walked freely into other people's flats and at times when people were receiving personal care. They told us they had reported this to management as they felt it was inappropriate, but no action was taken. We could not find any risk assessments to reduce incidents of people going into others living spaces. We also could not find evidence to acknowledge the impact on individual people.

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

●Staff prepared food for people in one flat for all the other people living in the flats. Apart from one person we did not see evidence that people were supported to prepare their own food, or that people were given the opportunity to choose from the menu, this would have enhanced their independence skills.

● Where people were at risk of choking staff had not made referrals to healthcare professionals, such as speech and language therapists [SALT] to ensure people's needs were met in the most appropriate way. In one person's care plan it stated, "I need full staff support when eating and all my foods need to be blended." However, there was no indication staff had taken advice from healthcare professionals on the consistency of the person's food to effectively and safely meet their nutritional needs.

● Although people had fluid balance charts there was no target fluid amount for guidance or oversight. We saw one person had only 200mls of fluid intake in one day, but no action had been taken leaving the person at risk of dehydration. When we asked staff about this person's drinking , they told us they found it difficult to encourage the person to take more liquids, but no advice had been sought from professionals to minimise the risk.

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

● Although people had been supported to attend health professional appointments such as dentists, opticians, follow up appointments and blood test appointments were not always followed up. For example, when we enquired about a person who appeared to be in pain the deputy manager told us, "We've been waiting for an appointment for endoscopy for them, it's been going on for a couple of years now." When we checked the person's health care plan we could see no evidence any enquiries had been made or further contact with the doctor this was – despite the person showing signs of being distressed. When the inspector brought this to the attention of the deputy manager they just requested the person's temperature to be taken.

● Where people required the monitoring of their bowel functions we found charts with daily recordings. However, there was no direction for staff to follow if they had concerns if someone had not opened their bowels for several days. In addition, there was no monitoring of people's bowel charts by senior staff despite people being known to experience constipation. The lack of oversight did not provide assurances timely actions were taken to consistently meet people's health needs.

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

● The physical environment was not decorated and adapted to an acceptable standard to ensure a safe and secure environment for people. Although bedrooms were personalised, and homely, communal areas felt impersonal and there was a lack of personal touches.

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.

● Some people living at the home had their movements restricted and this was not always reflected in the individual DoL'S assessments. For example, people were not allowed to access the kitchen areas, enter and leave the flats as they had locked doors.
● The management team were aware of their responsibility to notify the Care Quality Commission of authorised DoL'S.
● Not all best interest decisions were in place where needed and recorded. Where they existed these had involved suitable professionals such as healthcare and social workers.

Inadequate

Is the service caring?

Our findings

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

At 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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- At the time of our inspection there was an ongoing investigation into aspects of some staff members conduct and how they treated the people they supported. Some staff we spoke with reported that not all staff were kind and caring.
- People's privacy and dignity were not always respected. For example, one person was left sat on the toilet with the door wide open in a communal area. The staff member supporting them was aware but did not take action to maintain the person's dignity.
- We saw from staff meeting minutes a there were reminders about staff practices which included amongst other things, for staff to engage with the people they supported rather than sit and watch the television. During the inspection we saw little evidence that staff engaging with people.

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

- In people's care plans there was a lack of keyworker meeting records to demonstrate how people had been involved in expressing their views about their care and or supported in making decisions and choices.
- People were not always free to follow their activity programme. We heard examples of where people had to go out on an activity with another person due to staffing levels rather than follow their own choices.
- People were not involved in the day to day running of the service such as being supported to be involved in menu choices.
- People were supported to have access to an independent advocate. Independent advocates help people to have a stronger voice and as much control over their own lives as possible

Respecting and promoting people's privacy, dignity and independence

- People's privacy and right to confidentiality was not always respected. For example, a 'communication book' containing detailed private information about people was left out in an area accessible to anyone visiting the home.

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

- People did not receive care that ensured they had choice and control to meet their needs and preferences.
- People's goals and aspirations had not been identified. The care plans had not been written with people's involvement and were not produced in a way that was individualised to each person's needs.
- People were not consistently supported to follow their interests and chosen activities. People had weekly activity planners, but these were not always fully completed each week to reflect what people had been supported to do for fun and interest. We saw some people's activities consisted of going for a ride in the car, without any purpose.
- During the inspection we saw people mainly sitting in the lounge areas of their flats for long periods of time. We saw there were little activities taking place or staff interaction.
- People's desire for independence and access to the local community were not always supported and so did not reflect elements of the principles and values of Registering the Right Support Guidance.
- We found evidence that care plans were not updated in response to certain incidents and occurrences. This meant staff did not consistently have the most accurate guidance to ensure people were provided with responsive care and support to effectively and safely meet their needs.

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.

- Individual communication plans and guidelines were in place for people who did not communicate verbally or who had limited verbal communication. However, staff did not always show in practice they understood how to communicate with people in ways they understood to enhance people's sense of wellbeing and reduce incidents from happening. For example when we heard and saw one person was distressed a staff member was very dismissive telling the inspectors "They are always like that."

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

- People were not always supported to maintain relationships with their family. During the inspection we heard how one staff member told a relative they could not bring their family member home to visit them because they had been ill. However, when a social care professional checked the daily notes there was no record of the person being ill, and another staff member confirmed the person had not been unwell. The

staff member alleged it was because they were short staffed one morning, that was why they could not accommodate the visit home.

The registered persons failed to provide person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider has a complaints procedure and staff knew how to support people with complaints. We looked at the provider's complaints folder but could not find any recorded complaints.

End of life care and support

● At the time of the inspection no-one was receiving end of life care.

● Some people did have end of life care plans in place which included information about people's cultural and spiritual needs. Other people's end of life plans were being discussed with relatives where it was thought to be appropriate.

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.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

●The provider and registered managers quality checks had failed to identify the lack of reporting of incidents and medication audits had failed to identify the shortfalls in medicine management,
● People living at the home were not protected and supported to be safe as the registered manager and the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were inadequate auditing systems in place to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home.
● Staff were not effectively deployed so risks to the safety of people who lived at the home and staff were mitigated.
●Quality audits had not been effective. Audits carried out by the provider's representatives had failed to identify concerns raised at our inspection.
● When staff had reported incidents of abuse and or poor care practices to the management team no action had been taken. A staff member told us, management was not visible around the home environment. They said, "The manager stays in the office, we don't see her."
● The registered manager had not reported incidences of potential abuse to the local safeguarding authority so investigations could take place to ensure people's safety
● Accidents and incidents were inconsistently recorded and there was no auditing of these records to ensure the appropriate actions were taken and lessons were learnt. Safeguarding concerns were not routinely identified, investigated and reported to the appropriate authorities.
● The provider had failed to identify the training needs and competencies of staff in order to meet the clinical requirements of people living at the home compromising people's safety and welfare. One staff member had reported to management they did not feel competent administering medication. However, the staff member believed management had not listened to them as they were told they had to administer people's medicines.
● Staff competencies were not always completed to ensure staff were carrying out their role and responsibilities in an appropriate manner for example in medication administration and managing people's behaviour that may challenge.

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

Governance

● Concerns were raised with the Care Quality Commission [CQC] about the staff culture within the service, in that staff were not always open and care was not centred on each person.
● There was a lack of managerial support for staff, staff feeling they weren't listened to and staff being fearful of raising concerns. Staff member s described how they felt they were blamed when incidents happened. For example, one staff member said they were, "Targeted by a person because of the colour of her hair and the clothes they wore."
● The culture was one of staff doing for people rather than supporting people to be independent. Staff told us staff morale was very low.
● Staff were in control of people, the environment, and in control of what happened day to day.
● People did not consistently receive personalised care. People were not safe from a range of risks to their health, safety and well-being and people were not being safeguarded from abuse.

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
● Registered providers are legally obliged to send the CQC notifications of incidents, events or changes that happen within a required timescale. Statutory notifications ensure the CQC is aware of important events and play a key role in our ongoing monitoring of services. During our inspection, we discovered the registered provider had not made us aware of all safeguarding concerns and had not submitted the relevant notifications to us.

The failure to ensure the Care Quality Commission had been notified without delay of significant incidents are a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not partner's in their care or involved in service developments. There was a lack of people and relative's satisfaction surveys to identify how the home could make improvements.

Working in partnership with others
● There were different healthcare professionals involved with the service including, dieticians, dentists, doctor's surgery and pharmacies. The service did work with learning disability support services although we found referrals and recommendations made by them were not always followed through to ensure people's needs were effectively and safely met. For example, we saw guidelines from a speech and language therapist assessment had been completed [after concerns had been raised by a social care professional], but they were not available in the person's care plan for staff to follow.