Autism Care UK (3) Limited

Alexandra Park

Inspection report

Alexandra Way
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Alexandra Park is a campus style service supporting people with autism and a learning disability. People live in bungalows situated in extensive grounds. The site is accessed through a main administrative building. Some people receiving support from the service are 'residential' and receive accommodation and personal care from the provider. Some people are supported through an independent living model. These people rent their bungalows from a sperate landlord and receive personal care only from the staff at Alexandra Park. The service is registered to support a maximum of 32 people. At the time of the inspection there were 17 people being supported. Four people were identified as receiving 'residential' care and 13 people were supported under the independent supported living model of care.

People's experience of using this service and what we found

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.

Right Support: Evidence suggested people were not supported have maximum choice and control of their lives because systems to support and deliver care, and staffing numbers and staff training, did not support this. People were not supported to make decisions, engage in activities or access the local community. Care records and information received from staff, relatives and professionals indicated people, or their representatives, were not actively involved in care decisions and insufficient staffing meant people could not make choices easily. People were not always assisted with their medication in a safe and appropriate manner.

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 policies and systems in the service did not support this practice.

Right Care: Care was not person centred, did not promote people's dignity and failed to support their human rights. People had been left alone without staff support which had placed them at risk and caused them anxiety and distress. People's dignity was not supported because staff did not always have the correct knowledge and understanding to assist people in the way that would best support their care and wellbeing. Care records were incomplete meaning staff did not always have the correct information to deliver care. Staff training and supervision was not up to date and staff did not always have the right understanding or skills to support people effectively.

Right Culture: The ethos and values of the service were not embedded in care delivery. Management of the service was not robust with incomplete records or documents that were not effectively reviewed and

updated. Staff felt unsupported by management. Care staff were unaware some people were supported through an independent supported living process and some people were residents of the service and cared for under the regulated activity, 'Accommodation for persons who require nursing or personal care.' People living in supported living arrangements were not always able to exercise choice and live as ordinary life as other citizens. Care plans did not reflect the difference in care and did not support independence and choice. People were not actively involved in decisions about the service they received. The behaviour of leaders did not support people's involvement in care and help them to express their views and feelings.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 March 2022.) But there were no breaches of regulations. At this inspection we found the provider was now in breach of regulations. The service is now inadequate. This service has been rated requires improvement or inadequate for the last six consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

The inspection was also prompted in part due to concerns received about safeguarding issues, staffing and management of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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. The provider has taken action to address immediate concerns and is working with the local authority and safeguarding teams to address issues.

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 requires improvement 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 Alexandra Park on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing and staff training, medicines management, Infection control, person centred care and overall management of the service at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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

Inadequate

Is the service effective?

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

Requires Improvement

Is the service caring?

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

Requires Improvement

Is the service responsive?

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

Requires Improvement

Is the service well-led?

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

Inadequate

Alexandra Park

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was undertaken by one inspector. An Expert by Experience also contacted relatives of people who used the service, by telephone, to ascertain their views of the care provided. 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
Alexandra Park currently provides two types of care.

13 people in the service received care and support in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Four people living at Alexandra Park were supported with both accommodation and personal care, as if living in a 'care home' facility. People in 'care homes' receive accommodation and nursing and/or personal care as a single package under one contractual agreement. Alexandra Park is a 'care home' without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

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

At the time of our inspection there was no registered manager in post. A manager was overseeing the service and they had made formal application to CQC to take up the position of registered manager for the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service and liaised with the local safeguarding adults team. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service on the days we visited Alexandra Park. The Expert by Experience spoke on the telephone with seven relatives and one legal guardian. We also spoke with the manager, deputy manager, one team leader and six support workers. Following the inspection, we spoke on the telephone with two further support workers, an advocate for a person who lives at the service, a care manager and a social worker. We also received written feedback from another advocate. Additionally, following the inspection, we spoke on the telephone to the regional operations director.

Inadequate

Is the service safe?

Our findings

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

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

Preventing and controlling infection
• Systems were not in place to ensure people were protected from the risk of infection.
• Not all staff were wearing facemasks when supporting people in their bungalows. The manager told us it was the provider's policy all staff should wear facemasks. Quality reviews from January and April 2022 highlighted staff were not always wearing facemasks. Staff meeting minutes reminded staff facemasks were required when working in people's home.
• Monthly infection control audits had not been undertaken. Copies for the most recent infection audit documents were exact copies for all bungalows. Questions stated 'yes', measures were in place when they were no longer carried out or appropriate for supporting people in their own homes. For example, all audits stated people had their temperature taken twice daily. The manager told us this did not occur.
• Infection control training for staff was had either not been completed or was out of date.

Systems to monitor and mitigate the risk of infection were not being followed and staff had not received up to date training on the subject. This placed people at risk of harm. This was a breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Systems to ensure the safe management of medicines were not being followed.
• The service had recently been working with a member of the local medicines optimisation team to improve management of medicines across the site.
• Medicine administration records (MARS) had missing signatures, including medicines where it was important to maintain a daily dose. Staff told us this was a regular issue and they could not be sure if medicines had been given or not. One person was prescribed cream for their feet. There were gaps in the records for this item and no additional information as to where the cream should be applied.
• Issues occurred with the safe storage and management of controlled medicines. Controlled medicines are those that must be used and stored in line with specific legal guidance. Subsequent to the onsite inspection we were made aware of further issues with the safe management of controlled medicines.
• Competency assessments and observations of staff, to ensure they managed medicines safely, had lapsed over the previous 12 months, although a number had been undertaken recently. Training records showed the majority of staff required their medicines competency to be reassessed.

Systems to ensure the safe and appropriate management of medicines at the service were not in place or not adhered to. This placed people at risk of harm. This was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Systems to protect people from the risk of abuse or neglect were not in place.
• The service was under organisational safeguarding. Organisational safeguarding is a process employed by the local authority to monitor the service where there are multiple concerns. Safeguarding alerts were made to the local authority, although these records lacked detail and did not demonstrate what action had been taken to mitigate immediate risk.
• Two people had been left on their own for periods, without staff support, because staff had either left the service unnoticed or had failed to arrive for a shift. Staff told us there was not a robust system for monitoring if and when staff arrived for their shift. One staff member told us, "There is no system for logging in. If there is no night shift the keys are left in the office and there's no system for checking the day shift has turned up." The manager told us it was not regular practice for the duty manager to check each bungalow was staffed appropriately.
• Systems to ensure people's safety were not maintained. Staff told us one person's door alarm had been broken for some time. They said night managers did not physically check on the individual, but only did so through the lounge window.
• Training records shows staff had not received yearly safeguarding training, as required by the provider.

Systems to ensure people were protected from the risk of neglect and abuse were not robust or not always followed. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Staffing and staff recruitment were an ongoing issue for the service.
• The manager told us recruitment was ongoing and a number of new staff were due to start in the coming weeks.
• Duty rotas and other documents indicated provided hours did not always meet those hours contracted for by the local authority. Agency staff were used to cover shifts. The regional manager told us agency staff did not work alone with people, although records indicated lone agency workers supporting people on multiple occasions.
• Staff told us staffing issues meant people could not always engage in activities, where people required two staff to take them out safely. They said the second member of staff was often required to cover shifts in other areas. One staff member told us, "A while ago I covered an eight 'til eight shift. They didn't try to cover the other shift. They didn't have the eleven to five shift covered."
• Relatives and professionals said there were some very good and dedicated staff members working at the service, but a lack of a consistent staff team hindered people's care. A professional told us, "There are lots of good and well-trained staff. The problem is there is such a shortage of care staff." Relatives told us, "They are short of staff and they are leaving from the core team. They have a lot of agency staff. (Person) does not know them and cannot feel safe with strangers" and "One day they had no breakfast, no milk or bread on site. There was only one person on shift on Sunday and could not leave them to go shopping."

There were not always enough properly trained and experienced staff to support people live their daily lives and make life choices. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Appropriate recruitment processes were in place, including the taking up of references, reviewing any gaps in employments and carrying out Disclosure and Barring Service (DBS) checks. A newly recruited member of staff told us they were being well supported, but felt the initial training was quite rushed and intense.

Learning lessons when things go wrong

• The service was currently working to an action plan agreed with the local safeguarding team on issues to improve the service. A range of matters remained to be addressed.
• Where there had been incidents of concern these were logged. Where serious incidents happened staff were required to complete special forms (ABC charts - antecedent, behaviour and consequence charts) and undertake debrief sessions to review how better to manage future events. The manager said there had only been one recent serious concern.
• Professionals told us these specialist charts were not always well completed. One professional told us, "ABC charts are not completed correctly, and relevant information missed out, for example: dates, times and names of staff; both witness and authors." Some staff told us they had only recently been made aware that they should receive debriefing sessions following serious incidents.

Assessing risk, safety monitoring and management
• Assessment of risk was not always detailed.
• Risk assessments on people's care files were not always individual and often used standard phrases. Documents meant to mitigate risk, such as hospital passports, were not well completed. For example, one person could at times refuse to take medication. This was not noted in their hospital passport.
• It was not clear how reviews of risk had been undertaken and who had been involved in this process.
• Risks related to the environment and fabric of the service were undertaken. Fire alarm checks were carried out in the main building and some consideration of fire risk was undertaken in people's bungalows. People had emergency evacuation plans in place. The most recent fire drill had taken place in January 2022.

Visiting in care homes.
• People's relatives and friends were able to maintain contact and visit, as appropriate.
• Relatives told us people were supported to visit them at weekends or to go out for meals with them.
• Some relatives said they visited people in their bungalows, but this depended on how well the person was on that particular day.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience
• Staff training had not been maintained and competencies not fully assessed.
• The provider's training matrix showed considerable shortfalls in training. Staff needed updated training in important areas such as: infection control, safeguarding health and safety and positive behaviour support. The manager told us this deficit had been recognised and action was being taken to address the issue.
• Staff were required to have specialist training to help support people if they became overly anxious or lacked control. A recent update session had been provided but training records indicated further training was required for the majority of staff. Staff said they received email reminders about training and were paid for time but had not had opportunity to complete training.
• Quality audits undertaken in January 2022 identified staff required competency checks in medication management. These had only recently started to be addressed.
• Some staff told us induction training could be improved and felt there was minimal opportunity to shadow more experienced staff before working full shifts.
• Some staff said they had recently had supervision. Others said they had not received supervision sessions for a significant period. Supervision records were of variable quality. Staff told us that they had not had any recent annual appraisal.

Systems to ensure staff had the correct training and skills were not followed and staff had not received up to date training. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's choices were not always supported.
• Records showed people who required two staff when accessing the community were not always supported to do so. Staff told us this second staff member was often diverted to other parts of the service. One staff member told us, "They mostly have 1:1(staffing ratio) but needs 2:1 for activities. Their choices are limited to the numbers of staff." Staff said a lack of staff who could drive made it difficult for people to use mobility vehicles.
• Care plans contained a range of assessment documents, although these were not always well completed and up to date. They indicated people had been involved in decision making, but it was unclear how. One care record stated the care plan had been discussed with a person who was also described as being 'non-verbal.'
• Care plans contained goals people were to aim for. It was not clear how these goals had been arrived at

and how people were being supported to achieve these goals. Review dates for the identified goals were not always in place. Advocates for people told us they had not been involved or consulted about setting goals or agreeing care plans.
• Some people had fixed daily plans because they enjoyed routine. Professionals told us this was helpful to people. Staff were not clear if people could change their mind and carry out different activities if they wished to do so. An advocate said a person they supported had been told they could not have fish and chips twice a week. They were unsure why the person could not make this choice but felt it was to do with staffing or budgets.

People were not always supported to make choices about their care and they, or their representative were not always involved in decision making or reviews. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Alexandra Park supports both people who are residential (those provided with accommodation and care in a single package) and people who are in supported living accommodation (they rent their own bungalow and received care support separately).

In care homes, and some hospitals, restrictions on liberty is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• Two people had been left alone in their bungalows without staff support for a period. Staff told us the door was locked, although they understood people could get out. Professionals told us it was not clear if the system operated was within the DoLS guidance.
• Some people had best interests decisions, where they did not have the capacity to make the decisions for themselves. It was not always clearly recorded the decision made was the least restrictive, although the outcome was appropriate. There was some reference to family and advocates being involved in the decision, but this was not explicitly recorded. One family member told us, "They had COVID jabs and the spring booster. They lack capacity and had a best interest meeting to get it done."
• Where people had DoLS applications in place these were either in date or were in the process of being reapplied for. Staff were aware where people had orders made under the Court of Protection.

Staff working with other agencies to provide consistent, effective, timely care
• Systems in place did not always support staff working with a range of other agencies. Advocates and professionals told us decisions and care reviews often happened without their knowledge or involvement.
• Professionals raised concerns about the move of a person away from the service and how the process

could have been more co-operative. Despite various correspondence there were conflicting views about how the process could have been better managed.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access a range of health care facilities and health professionals.
• Care plans contained information about people's health needs. Staff had a good understanding of people's individual health issues and how these were supported.
• People were supported to make choices about meals and snacks. Staff encouraged people to make healthy choices, where possible, and supported them to plan meals and shop. We observed a number of people eating their breakfast or lunch and staff supporting them appropriately.

Adapting service, design, decoration to meet people's needs
• The Alexandra Park site is serviced by a company separate to the provider service. Responsibility for the upkeep of the site lay with the landlord company.
• Concern had previously been expressed about the state of the site and the upkeep of facilities. Maintenance of the grounds had been improved and the provider had taken on responsibility to paint the outside of the bungalows.
• Some bungalows were adapted so there was a minimised risk of people hurting themselves. Staff told us that it was sometimes difficult to get repairs carried out, especially when people rented the homes themselves. The manager told us a new company was taking over responsibility for the site and had recently surveyed the area with a view to refurbishment.

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

Supporting people to express their views and be involved in making decisions about their care
• People were not always supported to express their views or be involved in decision making about their care.
• Care plans had been reviewed but there was no evidence people's views had been sought or alternative methods of engaging with people had been employed. Care records had documents detailing how people had been involved with choosing their care team, but these were not well completed or simply stated people had not reacted negatively to new staff on shift. There was no evidence family members or representatives had been actively involved. One advocate told us, "Quite often I'm the only person with a direct link. I've not been involved in care reviews by Alexandra Park."
• Relatives told us they did not always feel involved in care. They said, "They were inviting me to appointments before but are not contacting me about any meetings now" and "They will speak with me on the phone and carers are not aware of what they are doing. I'm not invited to any meetings now."

People were not always supported to make active choices about their care and there was limited evidence alternative approaches had been used to gain involvement. This limited people's choice. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
• People's privacy and dignity were not always respected.
• One staff member told us they left a person's curtains open at night so the night manager could look through the window to check on the person.
• People's independence was not always supported. Relatives, professionals and staff told us people were not able to go out because there were insufficient staff. One staff member told us, "People can't make choices because there are no care staff. They spend their days sitting in the bungalows. Everything is stripped away from them."
• Relatives' views on people's dignity and independence included, "Staff help with personal care and are very respectful" and "They are well kept and always someone there. Will drag staff up to the kettle and can do small tasks with supervision."
• An advocate told us, "At this time the person I am supporting seems mostly settled and staff know them well enough to provide the support needed."

Ensuring people are well treated and supported; respecting equality and diversity
• Staff had a good understanding of people's care needs.

• People we spoke with told us they were happy with the support they received and had a good relationship with the staff who cared for them. People who could not communicate verbally looked happy and relaxed in staff company.
• Relatives were positive about the support offered by regular staff at the service. Comments included, "Staff know them well and understand their needs"; "I've been grateful for the care staff for over 10 years; they are real nice people" and "They are always changing staff and it takes them time to get use to them, but generally staff are okay."
• Relatives were less positive about the support provided by agency staff. One relative told us, "Agency staff will not go through the books to understand their needs."
• A professional told us, "There are lots of good and well-trained staff there that do some amazing work. But they are not all good." A staff member told us, "Some staff are very good and will go the extra mile, but they just get taken for granted."

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People's care was not always well planned and did not fully meet their needs.
• The manager told us they were currently reviewing all care plans, following issues raised as part of the organisational safeguarding process.
• Care plans were often incomplete. For example, one person's hospital passport was not fully complete and was missing important information regarding medicines. Another person's care records contained no information in areas related to nutrition, self-care, mobility, washing and dressing.
• Care plans were signed and dated at being reviewed, but there was no evidence of a review process and who had been involved.
• Staff had not signed care plans and other records to say they had read them or had signed empty or incomplete documents to say they had read them without updating them. An advocate told us, "Support plans and risk assessments are not signed by staff to say they have read and understood them. ABC charts not completed correctly, and relevant information missed out, for example, dates, times and names of staff."

People were not always supported to make active choices and have appropriate control of care to meet the preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 take part in activities or interests.
• Staff told us that because of staff shortages, or second staff shifts being cancelled, people could not always access the community. Comments included, "If they don't have 2:1 staff then they can't get off site. A while ago I covered the eight 'til eight shift. They didn't cover the other shift. They didn't have the eleven 'til five shift covered" and "He mostly has 1:1 but needs 2:1 for activities. His choices are limited to the numbers of staff. They need more staff to make sure people can go out."
• Staff told us the lack of staff able to drive meant people could not always make good use of their mobility vehicles. One relative told us, "They have a mobility car and three staff were all drivers. Now there is only one driver on shift so they can only go out for walks. Activities could be better."
• Relatives raised concerns about the ongoing lack of activities. Comments included, "They would go out for ice cream on the beach in the past and cannot understand why they are not taking them out" and "They are only walking around the site and will not take them to the pier."

People were not always supported to engage in activities they wished to enjoy or be part of the community.

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

• A person had visited a local holiday park for a long weekend. They told us they were looking forward to it before they went and later told us they had really enjoyed the weekend.
• Relatives told us they were able to keep in regular contact with people at the service. A number of people frequently went home to stay or visit relatives. However, relatives told us these visits are not always well organised. Comments included, "They drop them off with nothing on visits" and "They came home to visit and had their shoes on the wrong feet. I pointed this out to carers as they were in pain. I worry that they have slipped their shoes on, but staff are not checking."

Improving care quality in response to complaints or concerns
• The provider had a complaints policy in place and copies of the policy were in people's care files.
• The manager told us there had been no recent formal complaints made to the service.
• Relatives told us when they raised concerns, they did not always get a timely response. Comments included, "I've no trust on the place as all you get is lip service. I want my complaint to go further"; "I complain to staff but nothing gets done. It's a different staff member every time" and "The male manager did a fairly good job with few complaints. He dealt with things straight away. I'm happy but they are not exceptional. I give them 6/10."

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

• There were mixed views on how well people were supported with their communication needs.
• Staff spoke in detail about how they worked with individuals and learned their particular methods of communication. They talked about how people used signs or gestures to indicate their needs.
• People's care plans contained information about their communication style and preferences.
• Relatives told us people used a range of processes to communicate including Makaton sign language and cue cards. One relative told us, "They love the environment there; they understand him. He will point to things that he wants or take them to get something."

End of life care and support
• People's care plans contained information about end of like wishes, although not everyone had made decisions around this important time.
• Professionals told us information was not always accurate. One professional told us records stated they were taking action in this area when they had not agreed to do so.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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
• Systems to manage risk and ensure quality monitoring were not in place or poorly operated.
• Quality monitoring visits, by a member of the provider's quality team, that had taken place in January, April and May 2022 had not been followed up. Action points marked for immediate attention and had not been addressed. There was no attempt to engage with service users or their representatives as part of the quality monitoring process.
• Manager walkaround processes had only recently been introduced. These were largely tick box in nature and where actions were identified there was no evidence they had been followed up. Manager walkaround processes did not engage with people living at the service and seek their views. Daily flash meetings had only recently been commenced and were limited in detail and actions.
• Management processes were not robust or poorly implemented. Infection control processes were not followed, and medicines management processes were poorly implemented, despite the input of the local medicines optimisation team. Reporting mechanisms were not followed, leading to people not receiving safe and appropriate care. Key documents were not always dated and signed.
• Care plans were incomplete, despite being reviewed by the support manager. Care plan reviews had no documentation to demonstrate how these had been undertaken and had no evidence people had been involved. Daily records were poorly completed or missing.
• There had been no recorded incidents where the manager had been required to respond under the duty of candour regulations, although recent incidents of people being left alone would fall into this criterion. We advised the manager to review all incidents with reference to the duty of candour.

System to manage risk and improve quality were not robust and proper management processes were not followed. This place people at risk of poor care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service was not person-centred and systems and management did not empower and deliver good outcomes for people.
• The manager told us they service was not operating appropriately, They said, "Training was not being done and competencies not checked. Appropriate systems and safeguardings were not in place. I'm stripping

back to basics to get the processes in order." The regional operations director told us they were reviewing management systems at the service and agreed that more robust management was required for the service.
• Staff told us they did not always feel listened to. Comments included, "The managers don't give the support you need. They don't read the daily paperwork"; "Staff turnover doesn't help, especially the support managers who quickly leave. It needs some sort of continuity. I've raised issues about paperwork with managers, but staff are still not filling things in"; "Some managers are supportive and will get things sorted. Other managers do nothing about it, never appear and won't come out of the office" and "Management are understanding but under pressure. It needs a complete overhaul."
• Relatives had mixed views on management. Comments included, "Staff morale is poor as staff will talk to the manager and then have to go back to the bungalow with no support"; "The old staff have left because the home is not run properly." and "Managers would walk around the site and ask staff and residents if they had any issues. Staff are always in the office now with the two support managers."
• Professionals told us the manager and deputy manager were easy to contact and usually responsive to concerns.
• There was no difference in care planning for people who were 'residential' and people who were living in their own homes. Some staff were not aware people were cared for in two different ways. Care plans did not support people's choice and involvement in care.

Systems to embed and promote a person-centred culture at the service were not supported. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There was limited evidence to show people were actively involved in care and the running of the service.
• There were no records of recent meetings involving people. Bungalows had records of individual meetings, but these records were limited and did not demonstrate people were actively involved in decisions.
• Professionals and advocates said they had not been actively involved in care reviews and decisions.
• Relatives told us they found communication with the service poor. Comments included, "Nothing at all and no updates. In the past they would write letters and tell us what action they are taking" and "There are communication problems and we don't know about the issue until the next day."
• Staff meetings had taken place in April and June. For the June meeting 17 out of 43 permanent staff had attended. Issues raised include the poor take up of training, which remained an issue and the failure to wear face masks in bungalows, which continued during the inspection.
• Staff told us communication between them and management needed to be improved. The regional operations director told us they had received similar feedback from staff at the service.

Systems to actively engage with people, relatives and staff were not robustly implemented. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
• The service was under organisational safeguarding and was being overseen by the local authority commissioners and safeguarding adults team.
• The provider was working to an action plan agreed with the local authority. Some actions had passed the identified completion date and some actions marked as addressed remained an issue.

Working in partnership with others
• The service did not always work in partnership with other agencies.
• Professionals and advocates told us they were not involved in care plan reviews, setting goals and other activities linked to updating care for individuals.

• A range of organisations and professionals had raised concerns about the manner a recent safeguarding event had been dealt with and whether it could have been managed differently.
• People's care plans showed the service worked with a range of health professionals and relatives confirmed this.