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Fairglen Residential Home

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

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.

About the service
Fairglen Residential Home (hereafter Fairglen) is a residential care home that provides personal care and support for up to 12 people with a learning disability, autism or who have complex needs associated with their mental health. At the time of the inspection there were 10 people living at the service.

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

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 supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests. The registered manager and staff had deprived people of their liberty without the legal authority to do so. This meant the care and support model at Fairglen did not maximise people's choice, control and independence.

Right care:
People were often described by staff as having behaviours that could challenge themselves or others. However, there was limited information within peoples care records to determine what the behaviours that may challenge others were and what staff should do to support people effectively through this. The language used by staff to describe people within their care notes and on occasion when speaking with us, was disrespectful. This meant people's care was not person-centred and did not promote their dignity.

Right culture:
Institutionalised practices, in the form of exercise times, mealtimes and money management had helped to create a 'closed culture' at Fairglen. A 'closed culture' is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm. Fairglen increased people's dependence on the registered manager and staff who had limited understanding of how to support people effectively.
The failure to meet the underpinning principles of Right support, right care, right culture, meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

Although some relatives told us people were safe living at Fairglen, some relatives did not have confidence in the service and told us they did not feel their loved ones were safe or well looked after.

People were not always protected from the risk of avoidable harm. Where risks had been identified, sufficient action had not always been taken to mitigate those risks and keep people safe.

Safeguarding systems and processes were not always followed. The Registered manager did not always report and investigate safeguarding concerns. As a result of this inspection we made six safeguarding referrals to the Local Authority to ensure people were safely protected from harm.

There were insufficient numbers of suitable qualified, competent or skilled staff on duty to meet people's needs safely. We were not assured the service was following safe infection prevention and control procedures.

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 Good (published on 20 September 2018)

Why we inspected
We received concerns in relation to the management of risk, staffing levels, staff training, the management and leadership within the service and people's personal care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. However, further concerns and risks were identified so a decision was made to carry out a comprehensive inspection to include the key questions effective, caring and responsive.

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.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. 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.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified breaches in regulation in relation to safe care and treatment, safeguarding people from abuse, staffing, consent, dignity and respect, person centred care, notifications of other incidents and governance. Please see the action we have told the provider to take at the end of this report.

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

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

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

We will meet with the provider following this report being published and work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

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.

Fairglen Residential Home

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
The inspection team was made up of two inspectors and a medicines inspector.

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

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.

Notice of inspection
We initially carried out an unannounced evening visit, and we returned the following day.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

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 and spoke with six people living at the service, one relative, four members of staff, registered manager and the provider. To help us assess and understand how people's care needs were being met we reviewed four people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and quality assurance records. We spoke with four health care professionals, a representative from Plymouth City Council's quality assurance and improvement team (QAIT) and safeguarding team and three relatives.

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 requires 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

- Safeguarding systems and processes did not operate effectively in the reporting and investigation of allegations of abuse.
- One person made an allegation of physical abuse about a staff member. The registered manager was aware of this but failed to report it to the local authority and investigate the matter further.

On one occasion, a visiting healthcare professional informed the registered manager they had observed a staff member using unsafe manual handling techniques whilst supporting a person. The registered manager was aware of this but had failed to report it to the local authority and investigate the matter further.

- During the inspection on 18 November 2021, we raised a safeguarding concern with the registered manager that a staff member had knowingly allowed a person who was at high risk of choking, to be given a meal by another member of staff which put the person at significant risk of choking. We returned to Fairglen on 25 November 2021 and asked what action had been taken. The registered manager told us they had 'had a chat with [staff member]'. However, they had failed to report it to the local authority and investigate the matter further.

This meant the provider failed to operate an effective safeguarding system that reported and investigated concerns. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Although some relatives told us they felt people were safe, our findings were that people were not safe and were at risk of avoidable harm associated with their assessed care needs.
- Where people were assessed as requiring equipment to reduce risks, the equipment was not in place. One person had epilepsy and required a sensory mat to alert staff in the event of the person experiencing a seizure. However, the registered manager had failed to ensure it was in place. In addition to this, there was no care plan or risk assessment in place to guide staff in supporting the person during a seizure. This placed the person at increased risk of harm.
- Another person was prescribed urgent medicine in the event of having an epileptic seizure. However, staff on duty were unaware of this and did not know that it was available until it was discovered by the inspection team. This placed the person at increased risk of harm.
- People were not always supported in line with their care plans to ensure risks associated with eating and drinking were managed. One person's care plan identified they required a specific consistency of food. We observed staff supporting this person to eat a meal that was not the correct consistency. This put the person at increased risk of choking.
- Another person was assessed by a speech and language therapist (SALT) to be at risk of choking or

aspiration. During our observation we noted this person was being given fluids from a cup that was not in line with the recommendations specifically advised by SALT. Due to the increased risk of harm that both people experienced The Care Quality Commission made two safeguarding referrals to Plymouth City Council Safeguarding Team.

The failure to provide safe care and treatment for people with epilepsy, and the failure to follow dietary advice from professionals, put people at an increased risk of harm, This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines systems and processes did not always keep people safe.

● People's medicines support needs were not risk assessed, or care planned. Staff supported people to take their medicines but did not take their personal preferences into account about how or where they would like to take their medicines. There were no risk assessments in place for people who went out and took medicines with them.

● There were no individualised care plans which helped guide staff to give people 'as required' medicines. This meant, people may not have received their medicines when they needed them and could be in prolonged pain.

● Staff signed medicines administration records (MARs) following medicines administration. However, when a variable dose was prescribed (for example one or two tablets) the dose given was not always recorded. This meant it was not possible to tell exactly what medicines a person had taken. For some medicines the time of administration or the gap between doses was important to make sure they were safe and effective.

● Staff did not record the time of administration, so could not be sure of a safe gap between doses. For example, an antibiotic that should be given every eight hours, was recorded as being given at breakfast, lunch and teatime. Therefore, this might make it less effective in treating an infection.

● One person was at risk of harm from prolonged seizures as staff were not trained to administer an emergency medicine.

● People with additional health needs were supported by external healthcare professionals. However, we saw that two people had not been supported to access medicine reviews related to a potential adverse effect of a medicine.

People were at risk of not receiving their medicine safely. The systems in place did not support safe and proper medicines management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing arrangements at night and during the day did not address the risks associated with peoples care needs. We observed one person who had previously been taken to hospital with a Injury to their head following a fall, this person was left unsupported whilst staff were asleep. If this person was to fall again, they would be put at increased risk because staff were unavailable and there was no system to alert staff.

● There was no system in place to alert staff to an emergency. For example, call bell system, assistive technology and/ or emergency pull cords. The absence of a system to alert staff to an incident put people at an increased risk of harm.

● The registered manager told us there was no formal staffing assessment in place and a dependency tool was not used to identify what staffing was needed to meet people's need safely both during the day and at night.

● We noted that two people had lived in the service for a long time. However, staffing levels had stayed the same despite significant changes in both people's continence and psychological needs.

● We reviewed staffing rotas and noted that a member of staff who was away from the service had been included in the staffing compliment. Therefore, the rota was not an accurate reflection of the staffing provision within the service.
● Two people had epilepsy. There was no system in place to alert staff that people were having an epileptic seizure. One person had regular hourly checks between 9am and 9pm. However, these checks stopped during the sleeping night shift and staff had not received any epilepsy training.

The failure to deploy staff effectively and ensure that care and treatment was provided by staff who have the right training to do so safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recruitment processes in place which supported safe recruitment decisions. This included pre-employment checks to ensure staff were suitable to work with people living at the service.

Learning lessons when things go wrong
● Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored and reviewed.
● The findings of our inspection identified a culture that was not based on learning. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents.

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

Preventing and controlling infection
● People were not protected from the risk and spread of infection.
● We were not assured that the provider was doing everything possible to prevent people, visitors and staff from catching and spreading infections. Whilst the provider had in place procedures for visitors entering the service, we found these were not always being followed.
● We were not assured that the provider was meeting shielding and social distancing rules. People were not supported or encouraged to socially distance whilst in communal areas of the home. This placed people at risk from the spread of COVID-19.

The provider failed to ensure that risks relating to infection control and the transmission of COVID-19 were being effectively managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that staff were using PPE effectively and safely.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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.

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

- People's needs were not assessed. For example, two people who had recently moved to the service had not had their care needs adequately assessed. This meant, the provider had not ensured that staff had the skills and experience to be able to meet their needs safely and effectively.
- Daily records confirmed one person's needs had changed considerably and required a medical procedure to support them with their day to day needs. This person needs had not been reassessed and their care plans and risk assessments had not been developed to help guide staff in supporting the person in line with their individual needs.

The failure to carry out an assessment of the needs for people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff told us they had access to training and supervisions. However, the findings of our inspection demonstrated that staff support, and training was not effective.
- Staff had not received sufficient training to support them to deliver care effectively, in relation to positive behavioural support, mental health, capacity to consent, communication, epilepsy, continence care and working with people with a diagnosis of learning disability.
- Staff were not skilled in recognising that the language and terminology they used to describe people living at Fairglen was outdated, institutional and could cause offense.

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

- The providers supervision policy stated, staff at Fairglen who supported people with a learning disability or autism, will be offered clinical supervision in addition to scheduled supervision. This was not in place and the registered manager was unaware of this until it was raised by the inspection team.

Systems in place to help ensure staff received the required training and support were ineffective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet, supporting people to live healthier lives, access healthcare services and support

● One person lost 25 kgs in weight over a 10 month period. Staff did not know when asked if the person had been referred to a healthcare professional to review their weight loss. There was no information within the persons care records to indicate that staff were regularly monitoring their weight loss.
● Another person had lost 10 kgs over a 10 month period. Staff did not know when asked if the person had been referred to a healthcare professional to review their weight loss. There was no record in the person's care records of a referral being made. There was no information within this person's care records to show staff were monitoring their weight loss.

Failure to take adequate steps to manage and mitigate risk in relation to people's weight loss was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they were given a choice of meals. People were complimentary about the food.
On the days of our inspection people appeared to enjoy their meals.

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.

● A staff member described how three people would be prevented from leaving the service by themselves as it would not be safe for them to do so. The staff member confirmed that a Deprivation of Liberty Safeguards (DoLS) application had not been made to the local authority. There was no other legal basis or framework in place to support these restrictions.

Acting unlawfully to deprive people of their liberties whilst receiving care, was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported in line with the principles of the MCA. For example,
● We reviewed the mental capacity assessment in relation to finance for one person. This person had been identified as lacking capacity in relation to managing their finances. The mental capacity assessment did not contain details to inform who was consulted or what their views were regarding the decision.
● The registered manager held monies for and supported two people to manage their finances. These people's care records did not contain a mental capacity assessment to show they did not have capacity to manage their own money or that the decision to hold or limit their access to their money had been made in their best interests.

Failure to ensure people were supported in line with the principles of the MCA, was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● During our inspection we observed that hand towels in toilets and bathrooms had been bolted to walls to prevent the hand towel being physically removed. The registered manager told us this was because one person kept taking them.

This institutionalised practice demonstrated a lack of exploration in meeting this person's sensory needs, whilst placing restrictive measures on everyone else , and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's bedrooms were individualised, with their own items such as ornaments, pictures and other memorabilia.

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

- Although we observed some positive interactions between people and staff during the inspection, the language used by staff to describe the people they cared for within people's care notes and on occasions when speaking with us, was disrespectful, did not promote people's human rights or show they were valued.
- People were described by some staff as "having LD" meaning people had been diagnosed with a learning disability. Staff did not recognise that the language and terminology they used to describe people was outdated, institutional and could cause offense.
- One staff member described a person as "playing up again" and "We've been having trouble with (person's name)".
- Care records for one person described them as 'having a depression problem' and 'can't solve any problems and starting to be challenging'.
- Another person had been described as 'freaks out' in situations where the person became anxious and agitated. We also noted this person had been excluded from an activity on the grounds of 'health and safety reasons'. There was no explanation what these grounds for exclusion were or how best to support the person in such circumstances.

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

- People living at the service told us they were able to make some decisions about day to day matters such as what they would like to wear or how they spent their time.
- Staff told us they encouraged people to express their views and were involved as far as possible in making decisions about their care and support. However, throughout the inspection we did not observe staff encouraging, supporting and empowering people to make decisions.
- Most people living at the service had a support plan which contained basic information about people's needs, likes and interests. However, these were often outdated and did not apply to people's changing needs. This meant people's support needs were not always recognised.
- People we spoke with were aware of their support plans. However, people were not truly involved and seen as partners in their care. It was not clear how staff were engaging with people in understanding their rights, supporting them to have increased opportunities or enabling them to make informed decisions.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity. One person required support with continence. When staff entered this person's bedroom to support them with their continence, they were overheard by an Inspector saying, "oh no we can smell faeces". Staff did not recognise that the language used when supporting this

person with their continence needs was derogatory and undignified.

● During our review of one person's care plan we noted the language used was disrespectful and disempowering. The care plan included statements such as 'instruct (person)', 'staff should monitor (person). So that precautions can be taken for cleanliness and safety' and '(Person) will have to be taught all living skills'. Meaning the person should be instructed rather than supported.

● Another person was described in their daily notes as, 'can use toilet but don't know how to wipe', 'has eating problem and does not have behavioural problems'. This meant staff used labels which limited the support a person would get whilst casting judgement on their abilities.

● These concerns in relation to language used by staff had not been identified and addressed by the provider and/or by those in leadership roles which meant these practices had been allowed to embed within the service over time and become systemic.

● During a mealtime observation we witnessed a staff member taking a person's plate of food without communicating with them and then tipped half the contents of their plate onto another person's plate.

Not treating people with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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.

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

- We identified a poor culture where there were low expectations for people and an acceptance of situations and quality of life which would not be acceptable for most people. This was not in line with guidance contained in Right Support Right Care Right Culture.
- People were not supported to live their lives according to their preferred routines. Records for two people showed prior to the COVID-19 Pandemic they enjoyed going to church. However, when government restrictions were eased the registered manager failed to ensure these people were supported to reengage with activities and follow their faith. Attending church was extremely important for one person and there was a lack of sufficient evidence to show that all reasonable steps had been taken to support this person to practice their faith in a way of the choosing.
- For one person, the provider had failed to follow advice provided by an external health professional relating to the management and support of their sensory needs. As a result, the person continued to exhibit practices that may have caused ongoing psychological, emotional and physical distress.
- Another person's care records highlighted preferences relating to social activities and meaningful engagement which included outdated information such as going to the pub and bowling. A handwritten note in the persons care records stated the person could not do any of the above because of their health condition. There was no explanation of what this condition was and no evidence of further exploration or collaboration taking place to ensure the person had access to other meaningful activities.

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

- Three people were described by the registered manager and staff members as presenting behaviours that may challenge others. However, care records did not outline strategies and de-escalation techniques for dealing with behaviour that may challenge other people. This meant that care and support was not person centred and delivered in a consistent way.
- Another person's care records contained information that the person required a stoma. This was not included in any care plan or risk assessment for the person. This meant individualised care could not be planned effectively.
- We reviewed the care records for two people who lived quite independently within the service. Their care records contained no information about how they were to be supported to develop life skills or increase their independence.
- There was a lack of purposefulness to people's days. Staff told us they were unable to support people to plan their days effectively due to low numbers of staff. Relatives we spoke with told us, "There is no

stimulation that upsets me. [Person] use to do a lot", "There's no simulation staff don't seem to bond with anyone" and "There are no goals or structure to what they do".

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 failed to meet AIS in that the service did not identify, record, share and meet the communication needs of people living at Fairglen. Where examples of communication needs had been recorded these were out of date and did not meet the current needs of the people or national standards.

The failure to ensure people received care and support in line with their needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● No one was receiving end of life care and support during our inspection.

Improving care quality in response to complaints or concerns
● Relatives had mixed views as to how their complaints or concerns were responded to. Some told us they found it difficult to get a response if they raised any queries. Others were more positive and said they found the management team approachable.

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.

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

- The registered manager had introduced systems, processes and practices that restricted people to attend meaningful activities. Some people were restricted from leaving the service on their own accord. This removed the contact that people had within their communities.
- The registered manager and provider failed to comply with the services own quality assurance systems and failed to engage with people in a meaningful way that would empower people to speak up. This meant the registered manager and provider had created a closed culture at Fairglen.
- Institutionalised practices, in the form of exercise times, mealtimes and money management reinforced this closed culture, which increased peoples dependence on the registered manager and staff who had limited understanding of how to support people in accordance with the Health and Social Care Act 2008 and Right support, right care, right culture, which is statutory guidance issued by The Care Quality Commission (CQC).
- We expect providers of learning disabilities services to have regard to this, in order to maximise choice, control and independence of people using their services. The registered manager and provider were not aware of this statutory guidance.

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

- People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs. A poor staff culture created a lack of professional challenge that impacted on people's safety. All of this reinforced the closed culture within the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- The providers oversight and governance of the service was inadequate in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe, effective, caring and responsive sections of this report.
- Records and checks undertaken by the registered manager and staff were not always accurate and as such could not be relied upon. For example, people's care plans were incomplete or inaccurate. They did not describe people's needs and did not give staff instructions on how to meet those needs.
- The registered manager and provider did not have the skills, knowledge and experience to perform their

roles to the expected standard. The culture of the service did not reflect best practice guidance for supporting people with a learning disability and/or autistic people.

The provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities, however had failed to inform CQC about reportable events. For example, one person had suffered an injury as a result of a fall and was taken to an accident and emergency department. This was a notifiable event and should have been raised with CQC.

Failure to inform CQC of notifiable events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Working in partnership with others
● Whilst we saw some examples of where the registered manager and provider worked closely in partnership with GPs and district nurses. We also could not be assured that partnership working was fully embedded because of our findings in the effective and responsive sections of this report.
● Some professionals we spoke with did not feel that the registered manager and provider were always transparent and acted in the best interests of the people living in the service.
● Although sometimes advice was sought from healthcare professionals, we saw examples that recommendations made were not always followed up and/or actioned.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.
● The registered manager and provider understood their responsibilities in relation to duty of candour. Duty of candour requires that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment. However, relatives we spoke with gave a varied response when asked if concerns were shared with them.