Aston Care Limited

Glebe Villa

Inspection report

26 Glebe Road
Bristol
BS5 8JH

Tel: 01179541353
Website: www.astoncarehomes.co.uk

Date of inspection visit:
28 June 2022
29 June 2022
07 July 2022

Date of publication:
13 December 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Glebe Villa is a residential care home providing accommodation and personal care for up to seven people with a learning disability. At the time of this inspection there were six people in residence.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

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

Right Support
People's needs had not been fully assessed before they had moved to Glebe Villa. Staff had not received training to support people with a diagnosis of mental health, or dementia. One person was being physically restrained when receiving personal care involving three staff, staff had not received training in the use of restraint. There was a lack of records detailing when and why the person needed this level of support or any debriefs for staff.

People had access to health care professionals, but records of appointments were poorly recorded. There was no individual record maintained as staff recorded all health information in one central book for everyone living at Glebe Villa.

Right Care
People and their relatives said they were happy with the care and support. People had personalised their bedrooms. People said they enjoyed attending the social groups and attended these at set times throughout the week.

People were not being protected by the provider's recruitment process because not all checks had been completed before staff started working with people.

Staff were not always caring and spoke about people in front of others in a derogatory way. There were many examples where the structure of the home did not encourage people to have choice and control over their lives. People did not receive kind and compassionate care. Staff did not always protect and respect people's privacy and dignity.

Right culture
Not everyone was being supported in a way that enabled them to have choice and control in their daily lives. The routine of the home was potentially having a negative impact on people especially two people who were the most recent admissions to the home. People all ate and had drinks at the same time every day. Each person attended the same activities. People's aspirations and goals were not explored to ensure they were living the life they wanted to.

There was a lack of oversight from provider and the registered manager regarding quality assurance within the service. Risks to people's health were not always identified. Risks relating to the environment had not been mitigated to keep people safe. The registered manager had not consistently submitted notifications to the Care Quality Commission or made referral to the local authority in respect of safeguarding concerns.

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 (20 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received about another home operated by the same registered provider. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring and well led sections of this report.

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

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

We 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Glebe Villa 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 ensuring people are safe in respect of safeguarding and the use of restraint, managing risks, staffing levels and training, people being treated in dignified and respectful manner, governance and the culture of the home.

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
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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always 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 well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Glebe Villa

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 conducted by one inspector.

Service and service type
Glebe Villa is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Glebe Villa 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided and spent time with others observing interactions with staff. We spoke with three members of staff and the registered manager. We spoke with three relatives and contacted three health and social care professionals about their experience of the service.

We reviewed a range of records. This included two people's care records, daily records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We continued to seek clarification from the provider to validate evidence found. We looked at training data, care plans and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- We could not be assured of the safety for one person living in Glebe Villa because staff had not been trained in the use of restraint. Staff told us one person was supported by three staff to have personal care. Staff confirmed they held the person's hands to prevent injury due to the person hitting and scratching staff. There were also incidents where staff had recorded they had removed the person from an area in the home. It was not clear what level of intervention was used. There were no records detailing the restraint used, when, by who, whether the person had come to harm or if staffs' actions were in line with legislation and good practice guidelines. There was no debrief after these incidents for staff.
- There was no evidence from talking to the registered manager or from the person's care documentation that staff had explored whether there was a least restrictive means to support the person. No other health and social care professionals had been involved in the decision process for the use of restraint. The registered manager said they had adopted this practice from the person's previous care home.
- There were two incidents in January 2022 where a person had intimidated and attempted to hit out at people living in the home. There was a further incident where another person had taken a bread knife into the communal area, when there was an altercation, no one was physically harmed on this occasion. None of these incidents had been raised as a safeguarding alert to the local authority or the Care Quality Commission.
- Staff confirmed they had safeguarding training but when asked what their role was in respect of safeguarding they talked about safe moving and handling but were not able to describe any forms of abuse or the role of the local authority. They did say they would discuss any concerns with the registered manager.
- People told us they felt safe. However, we observed a person go to their bedroom because a person was becoming anxious in the lounge and on another occasion a further person moved from the lounge to the conservatory until the person settled.

Systems had not been established to assess, monitor and mitigate people from potential abuse. This placed people at risk of potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- We were not assured of people's safety. Two fire doors were propped open with a wooden door wedge, which meant in the event of a fire people would be at risk. Not all the radiators in the home were covered, or a risk assessment to support the reason why they were not covered, which meant people were potentially at risk of being scalded. On the 7 July 2022 the registered manager confirmed the radiator covers had been purchased and they would be installed the following week in response to our feedback.
- Risks to people and visitors had not been fully documented. There had been two incidents where health

and social care professionals had been put at risk due a person not allowing them to leave without staff assisting. There was no risk assessment on how staff should intervene and the importance of sharing this information with visitors on arrival.
● We observed a person being assisted from a sitting position to standing position using an unsafe technique. There was a lack of guidance for staff in respect of the person's mobility and the assistance they needed and how this should be done safely. Staff told us there was a risk to the person when using the stairs. There was no guidance on how staff should support the person, although staff told us they walked behind the person when on the stairs.

Systems had not been established to assess, monitor and mitigate risks to people ensuring their safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were not protected because new staff had not been through a robust recruitment process. Not all staff had completed their application forms with their full employment history, and one member of staff had only recorded their education, which was dated in 2004. Not all records had been filed to demonstrate a robust recruitment process had been completed, such as interview records and references. Some of these were held electronically or in a plastic bag in the registered manager's office and were waiting for filing. These had been located after the first day of the inspection.
● One member of staff had only one reference from an employer that was not mentioned on their application. One member of staff had started work for a period of two months before their Disclosure and Barring Service (DBS) check had been received. References for the third member of staff could not be found until after the inspection. A DBS check provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider did not always follow their recruitment process and ensure adequate checks were in place for new care workers. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels had not been reviewed in response to the two new people who had moved to the home. One person needed three staff to support with personal care. There was only one waking and one sleep in staff at night. This person was not being supported at night in accordance with their care plan especially in light that they were nocturnal and often refused to go to bed. Because there were only three staff working during the day this had an impact on other people living in the home as when all three staff were supporting this person the other five people had no staff to support them.

The failure to ensure sufficient skilled staff were deployed to provide people's care and support was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
● Medicines were stored safely and administered in line with their prescription.
● Staff had received training and their competence assessed. One member of staff said they were able to support with medicines so long as a senior member of staff was supporting them as they were learning this role.
● There was a lack of management oversight on the medicines as the last audit to be completed was in

excess of two years ago. No other audit has been completed until an external pharmacist completed a visit in January 2022. They made a number of recommendations such as ensuring medicines were dated when opened, temperature checks to be completed daily and the need for controlled stock cupboard. These had subsequently been addressed by the staff and the registered manager.

● The staff and registered manager ensured people's behaviour was not controlled by excessive and inappropriate use of medicines and ensured that people's medicines were reviewed by the person's GP in line with these principles. This was in line with the principles of STOMP (stopping over-medication of people with a learning disability, autism or both).

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely. There was one occasion when the registered manager and a member of staff were in the office and neither were wearing masks as these were under their chin.

● We were assured that the provider was accessing testing for people using the service and staff.

● 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.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The registered manager demonstrated they had followed the government guidance on visiting arrangements. Friends and family were able to visit the home with no restrictions. This allowed people to stay in contact with their relatives during the COVID-19 pandemic.

Learning lessons when things go wrong

● Staff had failed to record incidents and near misses, which did not help keep people safe. One person had fallen and there was no accident record, just a written note to 'discuss with the GP' dated June 2022. A member of staff said they had been hit by a person when out attending a social club, but an incident report had not been completed. This meant these accidents and incidents could not be fully investigated with lessons learnt and shared with the team.

● A review of the accident and incident file showed the last accident to be recorded was in 2019. This also demonstrated a failure to review and investigate when things went wrong and a failure to learn from events to improve safety for people and staff.

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.

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

- Our inspection findings evidenced the service was not meeting some of the underpinning principles of Right support, Right care, Right culture. For example, people's care plans did not identify any goals or aspirations. Everyone in the service attended the same social group with no evidence that alternatives had been explored for the people.
- The registered manager had failed to complete a comprehensive assessment for two people who had recently moved to the home to ensure they could meet their care and support needs. There was no pre-admission assessment for one person and the document for the other person was blank. Staff told us they had not received suitable training prior to one person moving into the service to enable them to meet the person's needs.
- People were not always enabled to make choices or have their wishes accommodated. For example, staff told us, lunch time was 11.30am and the evening meal was at 3pm. Staff told us, this was the times people liked to eat. Two people told us they went to bed at 7.30 pm and breakfast was at 6am. They indicated it was their choice. This indicated institutionalised practice due to a regimented routine, which people were not enabled to deviate from.

Staff support: induction, training, skills and experience

- Staff were not always supported to access training that was specific to people's support and health care needs. For example, training in supporting people with a diagnosis of mental health, learning disability, autism, dementia and the use of restraint.
- The registered manager and the staff had completed online training such as moving and handling, safeguarding and person-centred care. This had not been put into practice such as when supporting a person to mobilise and the poor culture in the home. There was a lack of understanding when incidents need to be reported to safeguarding and the lack of understanding of the legal implications in respect of the use of restraint as discussed in the safe domain.
- It was not clear whether staff had completed a comprehensive induction. The registered manager showed us a certificate for three staff showing they had completed the knowledge part of the training of the care certificate, but it was not clear what elements they had completed in respect of the 15 components that make up the care certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
- There was a plan for supervisions. However, of the three staff's records sampled only one member of staff had received a formal supervision with their line manager, which had taken place in 31 January 2021. Two of the staff had started working in the home in February 2022 and there was no evidence of any formal

supervision to provide support and monitor their competence. There was a failure to address and identify and make improvements through regular supervision of staff. Staff had signed documents such as food hygiene rules, but these had not been signed off by the registered manager to ensure staff had fully understood.

People were not supported by staff who were adequately trained and supported to meet people's assessed needs. This was a breach of regulation 18(2) 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.

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, 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.

● Applications had been submitted for people living in the home who lacked capacity to make decisions on whether to live in Glebe Villa. Whilst the registered manager had clearly recorded the use of restraint for one person in their application. This had not been captured in the authorisation completed by the local authority. Therefore, the person potentially was being restricted by the use of restraint unlawfully, which had not been identified by the registered manager or the provider.
● There was no evidence of a review with the aim of reducing the restricted practice. There had been no involvement of other health and social care professionals such as the community learning disability team in drawing up a positive support plan. The registered manager told us they had adopted the care plan from the person's previous placement.
● Not all staff were aware of who was subject to a Deprivation of Liberty Safeguard and the implications this had on their care.
● Best interest decisions were recorded in respect of support with medicines, finances and personal care.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not provided with meals that met their personal preferences. One person's nutritional care plan noted the person often declined food. The care plan lacked guidance on what the person liked or disliked, or guided staff as to how to support the person to make their own food choices and the records they should complete. This person was a pescatarian and on one occasion had been given hotdogs. There was no evidence this person had been offered fish. We observed staff offering the person food on three occasions and this was declined. This had not been captured in the person's daily records.
● One person's food chart indicated that they eaten potatoes, cheese and beans on the majority of the days for a period of 13 days. On one of the 13 days they had only eaten a bowl of cereal and a slice of cake during

a 24-hour period. Fluid intake had not been recorded for 11 out of the 13 days sampled and then it was recorded 'just sips of water'. The person was observed eating a biscuit on the first day of the inspection and this had not been captured on the record.

● Three people told us they liked the food and they all helped to plan the menus on a Sunday. One person said, "The staff cook what I like" and another person told us they had liked the pudding they had been served. There was no evidence people were supported to learn new skills in food preparation. One person said they liked to make cakes but could not remember the last time they did this.

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

● Improvements were needed in the records relating to people being seen by a health and social care professionals. A record of attendance of health and social care was in a single A4 hardback book and contained information for the six people living in the home. There were no individual records so that information could be accessed promptly, and the record did not detail the nature of the appointment, the outcome or if any follow up was needed.

● Oral health care plans were in place. One person had been identified on admission as needing the dentist. The only record to confirm attendance was in the manager's note pad. The registered manager said they were unable to find an NHS dentist and the person had attended privately. It was not clear which dentist they had attended, if there was a need for further treatment or the outcome of the appointment.

The provider and registered manager had failed to implement robust governance systems to ensure records were maintained demonstrating how they were meeting people's needs. The provider failed to ensure that action was taken to improve the care people received. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Glebe Villa was in keeping with other homes in the local area and in close proximity to shops and public transport links.

● People had personalised their rooms. Not everyone was included in decisions relating to the interior decoration and design of their home. This was because the registered manager went to buy curtains on the second day of the inspection for a person, but this person was not involved in the decision process. A relative said they had recently met with the provider who said they would be replacing carpets in their loved one's bedroom and the hallway.

● People had access to a small lounge and a conservatory. People were making use of these spaces. A filing cabinet and the medicine cabinet was also place in the small lounge, which detracted from the homely appearance of this area. At the last inspection the registered manager said the provider was looking to add an extension. At this inspection they said they were still waiting for planning permission.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- People were not treated with respect and dignity. We observed two members of staff talking in a derogatory way on two separate occasions in relation to continence care and an incident that had happened at a social club where a person was not happy. These discussions were inappropriate and were had in front of other people.
- People were not treated in a respectful way and as an equal adult in their own home. One person had asked if they could have a biscuit at 6pm. A member of staff told the person they had cleaned their teeth and they had to wait till later. Another person asked for help with going to the toilet on three occasions. A member of staff said, "You have just been your nappy does not need changing".
- Interactions between staff and people were task focussed for the majority of our visit, such as when people were being offered a drink, something to eat or whether the person needed assistance for personal care. The majority of the engagement involving people was between each other and the inspector.
- The lounge did not promote an inclusive, homely atmosphere for people. Due to the layout of the lounge it was difficult for the staff to sit with people. The majority of the time staff stood or sat on a coffee table close to the medication cupboard or stood in the hallway leading off from the lounge leading to the kitchen.
- Although people told us they liked living at Glebe, one person told us they had lived at the home for 27 years. Another person told us they liked living with their friends. One person told us they liked some but not all of the staff. They shared an example with the inspector and the registered manager, where they did not like how a member of staff had supported them with a shower. The registered manager said this would be investigated.
- Relatives generally spoke positively about the service. However, two relatives raised concerns about the lack of activities that were taking place.

Respecting and promoting people's privacy, dignity and independence

- Confidentiality was being breached as information relating to people's health care appointments was recorded in a one central book for everyone living in the home. This meant if a person or their representative wanted to view their own records they could see the other people's entries.
- Two people's privacy was being compromised due to ill-fitting bedroom curtains. The registered manager said the provider had replaced the curtains the year before in one person's bedroom. This had not been noted or rectified by the staff or the registered manager until our observation. The registered manager went shopping alone for this on the second day of the inspection with no involvement of the person.
- A relative told us, they purchased clothing for their loved one. In addition, three people told us the registered manager purchased their clothes for them or their relative completed this for them. One person

said they enjoyed going shopping, but they were not involved in shopping for their clothes. This demonstrated a failure to promote people's independence or respect their individual preferences and did not lend to person centred care or involvement of the person.

● People told us they were involved in some household chores such as folding laundry and the cleaning of their bedroom. One person was observed making their own drink. People had access to the kitchen when staff were not cooking. A note was put on the door stating that the kitchen should be locked when staff were cooking. This did not encourage independence and the learning of new skills.

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

● People were not consistently involved in making decisions about their care. Two people told us that in the past they had resident meetings, but these had not happened for some time. Not everyone was sure who their keyworker was and whether they had one. One person told us their keyworker had left and another person was told by the registered manager their keyworker was on holiday.

● People told us they were involved in making decisions on how they spent their time and they were involved in menu planning every Sunday with a member of staff. Three people told us that drinks were offered at set times. The last drink was at 5.30pm. This did not lend to people being involved in making decisions on how they wanted to be supported due to restrictive practices at the home.

People were not supported in dignified and respectful way that encouraged people to have autonomy, independence and control over their lives. Systems had not been embedded established to assess, monitor and mitigate risks in respect of the culture of the home and care and support of people. This placed people at risk of harm and breached their human rights. This was a breach of regulation 10 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The registered manager and provider had failed to ensure the quality assurance systems were reliable, robust and effective to drive improvements. For example, they did not pick up the areas found at this inspection such as fire doors being propped open and radiators not being covered. They had not identified the gaps in the recruitment information, care plans and risk assessments and the concerns relating to the culture of the service. They were not protecting people's rights in relation to the use of restraint. There were shortfalls in training and the supervision of staff.
- Whilst improvements had been made to the medicines systems this had been in response to an external pharmacy visit. The last formal audit the registered manager had completed on the medicines system was in 2018. There had been no audit checks completed on the environment, care plans, recruitment information, infection control, hand hygiene and other areas related to operating a care home.
- We requested evidence of checks that had been completed by the provider, on day two in person and twice via an email to the registered manager. This was provided on day 3 of the inspection. The provider had visited in September 2021, January 2022 and April 2022. They had spent time in the service but there was no evidence they had reviewed any records or measured the quality in line with the legislation and other good practice guidelines such as Right Care, Right Support, Right Culture.

The provider and registered manager had failed to implement robust governance systems to ensure the quality and safety of the care provided met people's needs. The provider failed to ensure that action was taken to improve the care people received. This was a breach of Regulation 17(Good Governance) 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

- There was not a culture that promoted person centred care, which was inclusive as detailed throughout this report. Whilst people told us they were happy living at Glebe Villa and relatives said they were satisfied with the care, the focus of interactions between staff and people were task led and staff practice was restrictive.
- The provider and registered manager did not always consider the impact on people when new people were admitted to the home. This was because the compatibility and risks to people had not been considered when a new person had moved to the service.
- There was no consideration with how to meet people's long term-aspirations and how they would like to

live their lives.
● The service was currently not meeting legislation, guidance and best practice in relation to supporting people with learning disabilities and autistic people. This included not meeting Right support, Right care, Right culture, and National Institute for Clinical Guidance (NICE).

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 had failed to report safeguarding concerns as discussed in the safe domain. Two people had an authorisation for a deprivation of liberty safeguard in December 2021 and June 2022 and the registered manager had not notified us of these until we inspected.

The provider and registered manager had failed to implement robust governance systems to ensure accidents, incidents and safeguarding were reviewed and reported in a timely manner. The provider failed to ensure that action was taken to improve the care people received. This was a breach of Regulation 17(Good Governance) 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; Continuous learning and improving care
● There were gaps in staff training including induction and training to enable them to support people effectively. As identified in the effective domain there had been a failure to put training that had been completed into practice.
● The provider had introduced a new electronic care planning system. The registered manager said they had experienced issues and they only used this to record what support people had received on a daily basis. One member of staff was not confident in using the system and asked another member of staff to show the inspector how it worked in practice. It was evident the team needed more training to embed the electronic planning system. There was also issues of retrieving data such as food and fluid charts and this was forwarded to the inspector via email after the inspection.
● Relatives said they were kept informed and had regular contact with the registered manager and the staff team. They said the staff were friendly, polite and engaged with them when they visited.

Working in partnership with others
● The registered manager and provider had regular contact with community health service, the local authority COVID team and kept abreast of any changes in policy provided by Public Health England, CQC and the Department of Health and Social Care.
● Visiting health and social care professionals spoke positively about the registered manager and the staff. One professional said that they found the registered manager to be very helpful and supportive.
● The registered manager was not involved in local forums such as the local authority provider meetings or the registered manager's network, where they could share good practice and improve the service.
● The provider had four other homes registered with the Care Quality Commission, but the registered manager said they did not meet up to share and discuss ideas and improve care and support for people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Systems were not in place to ensure people were kept safe from harm as risks had not always been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems had not been established to assess, monitor and mitigate people from potential abuse. This placed people at risk of potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not have systems in place to ensure their recruitment process was followed so adequate checks were in place for new care workers.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Systems were not in place ensuring people

were supported by staff who were trained or supervised to meet their needs and keep them safe.

Sufficient staff were not being employed to support people keeping them safe and meeting their needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulations were not being met: The provider had failed to ensure people were treated with dignity and respect. The structure of the day meant people did not have autonomy, independence and control on how they wanted to live.

The enforcement action we took:

Warning notice with a date of compliance 30 October 2022

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems were not in place to ensure people were kept safe from harm as risks had not always been assessed.

The enforcement action we took:

Warning notice with a date of compliance 30 October 2022