Parkgate Manor

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Inspection report

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Date of inspection visit:
19 January 2022
20 January 2022

Date of publication:
14 March 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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
Parkgate Manor is a residential care home providing personal care to 28 people at the time of the inspection. The service can support up to 40 people. The service was a large manor house, set in private grounds within a small rural village. People had their own bedrooms and there were shared bathrooms, eating and living areas.

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

Right Support
The model of care and setting did not maximise people's choice, control and independence.

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.

Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. The provider had not always acted to manage infection risks. People's medicine support was not being managed safely. There were not always enough staff to safely meet people's needs. The design and layout of the premises did not support or promote people's independence.

People's needs were not always holistically assessed to consider what people wanted and needed and people did not always achieve good outcomes that effectively met their health, social and emotional needs. Staff did not always have the necessary skills, knowledge or experience to know how to meet people's needs.

Right Care
Care was not always person-centred or promote people's dignity, privacy and human rights.

Staff did not always communicate or support people in dignified or respectful ways. Staff did not always offer people choices or involve them when supporting them with activities, medicines and meals. We saw staff often moved people in wheelchairs without asking their permission.

People's strengths, levels of independence and quality of life was not always accounted for when planning and reviewing their care, and people were not involved in this process. Staff did not always communicate in accessible ways with people. Recommendations and actions identified by partnership agencies regarding people's support needs had not always been implemented or consistently followed to ensure people achieved good outcomes.

Right culture
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure all people using the service could lead confident, inclusive and empowered lives.

People were not being supported to regularly identify, or review, on-going individual aspirations and life goals. People did not have support to follow their interests and take part in appropriate social activities. Staff and health and social care professionals told us the values and attitudes of staff and management did not empower people and there was a long standing unchanged culture of "doing things the way they had always been done" which was causing a lack of empowering person-centred support to continue.

Internal systems of staff and management appraisals and supervisions were not operating to help staff to understand and fulfil their responsibilities and support staff to be positively accountable for their performance. Staff morale was very low, and we were told there was not an open or transparent culture within the service. People and staff were not encouraged to contribute to developing the service.

There were minimal internal quality assurance systems and processes to audit or review service performance and the safety and quality of care. Where checks and audits were carried out, they had not always identified or prevented issues occurring or continuing at the service. Where issues had been identified, the registered manager and provider had not always effectively overseen or ensured actions were taken to maintain or improve the quality and safety of the support being delivered at the service.

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

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. The inspection was prompted in part due to concerns received about staffing and people not being kept safe from abuse. A decision was made for us to inspect and examine those risks.

Follow up
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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to risks, abuse, dignity and respect, person-centred care, consent, staffing, notifying CQC and displaying CQC ratings 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.

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 act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Parkgate Manor

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors carried out the inspection.

Service and service type
Parkgate Manor 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.

Two days after our visits to the service, the registered manager resigned with immediate effect whilst this inspection was on-going to take up a care co-ordinator role at the service. The provider's managing director then assumed acting manager responsibilities until a permanent registered manager is recruited.

Notice of inspection
This inspection was unannounced.

What we did before inspection
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider, the local authority and other agencies and health and social care professionals. This information helps support our inspections. We used all this information to plan our 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.

During the inspection
We spoke with people who used the service and three relatives about their experience of the care provided. We communicated with people who used the service who were unable to talk with us but used different ways of communication, including objects and their body language.

We spoke with six members of staff including the registered manager.

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

We reviewed a range of records. This included people's care and medication records and records relating to the management of the service. We looked at staff files in relation to recruitment and staff supervision.

After the inspection
We continued to review care and management records and seek clarification from the provider to validate evidence found. We spoke with the acting manager and one staff member via telephone. We spoke with and received feedback from eight health and social care professionals who regularly worked with staff and people at the service.

Due to the level of concerns we identified, we sought immediate assurances from the provider regarding actions being taken to reduce risk to people at the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

●Risks to people's health and welfare were not always assessed, monitored and managed safely. People with risks related to complex needs, including aspiration (choking), behaviours that may challenge, epilepsy, constipation and skin integrity did not have enough detail in their care plans or risk assessments about how to manage risks to their health and well-being safely.

●People's care plans and risk assessments were not being reviewed and updated regularly or when needs changed to check agreed risk management actions were still needed or were safe enough. People, or people acting in their best interests, had not always been involved in deciding how to manage risks, to help make sure people's personal freedom, independence and choices were respected. This increased the chances people could get unsafe support.

●Staff were not aware of the safest way to reduce risks to people with constipation, aspiration and behaviours that may challenge care needs, and were supporting these people in inconsistent ways. These people's support with managing risks was not being monitored by senior staff or management to check they were as safe as possible. This had placed people at avoidable risk of harm to their health and well-being.

● For example, In accordance with their assessed needs staff were not elevating a person to a safe angle whilst in bed to reduce the chance they may aspirate or become unwell with chest infections. The person had a history of experiencing confirmed or suspected chest infections.

●Staff and management did not know how to safely support people who were physically challenging and were supporting them in inconsistent ways that were not risk assessed or monitored. This included staff currently using unauthorised physical, isolation and chemical intervention techniques when supporting them. This was immediately fed back to the provider to ask them to act to address these issues.

●Staff were not following agreed actions to reduce risks caused by constipation for one person, including providing a safe diet, monitoring their health and bowel movements and giving them the correct dose of laxative medicines. This placed the person at risk of harm to their health and increased the chance they may have experienced avoidable pain and discomfort.

Using medicines safely

● Medicines were not safely managed. People were not always given the correct amounts of laxative medicines they had been prescribed. Staff were not supporting some people with the right way to take their medicines or giving them the amount of medicine they had been prescribed. This increased the risk their medicines would not work as well or they may be having too much medicine, which could be harmful to their health.

●People who had been prescribed 'as and when' (PRN) medicines for behaviours that may challenge and constipation did not have adequate protocols or information in their care plans to direct staff about when and how to safely give people these medicines. Staff were administering PRN medicines to people without

always recording the reasons why they had been given, and this was not being checked by senior staff or managers. This increased the risk people may be given medicines they did not need or may not have medicines when they needed them.

● Medicines requiring refrigeration were not always stored consistently at safe temperatures, increasing the risk they might not work. The medicine fridge and storage room were very dirty. The medicine fridge contained standing water that medicines had been left sitting in. Water used to help people take their medicines was stored in open containers containing flecks of dirt, increasing the chance of cross-infection.

●Medicine audits by staff were not effective. Internal audits had either not identified or acted to resolve issues such as unsafe storage, administration and recording of medicines.

●Recent external pharmacy audits had found systems for ordering and reviewing people's medicines were not working well and issues had continued for long periods without being resolved by staff. This was resulting in wasted medicines and excess stock being stored. This increased the chance of theft or misuse of medicines occurring.

●There were differences between information in people's care plans and the directions on their prescriptions and MAR about how and when to give them medicines. For example, people had been prescribed a dose of half to one tablet of their medicine, but their care plan stated they required one tablet only. This increased the chance staff may not know how to support people to have the right medicines.

Staffing and recruitment

● The service currently had several unfilled support staff vacancies for which recruitment was on-going. In addition, the service had been experiencing high levels of staff sickness, some of which was due to Covid-19 infections, but not exclusively. There were not always enough support staff available to safely meet people's needs according to then provider's assessed safe levels of staffing. The provider employed agency staff to cover staffing vacancies. The registered manager and staff told us agency staff did not always turn up when booked, so there were not always enough staff working.

● Rotas were not always managed safely. Staff told us they did not feel they had the right skills to support people with behaviours that may challenge. Permanent staff told us agency staff did not always have the right experience and skills to support people safely. An agency staff member said they did not know the needs of the person they were supporting, including how to manage any risks.

●The head of care and registered manager had regularly worked directly supporting people for a long period due to staffing shortages. They told us due to this they had neglected their own roles and responsibilities, resulting in safety and quality issues remaining unresolved.

Learning lessons when things go wrong.

●Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not effective. There had been a high number of challenging behaviours, unexplained bruising and falls incidents reported. Staff and management had not always acted quickly to review incidents or report to other outside agencies if necessary, to help decide actions that could prevent these incidents happening.

●The registered manager told us that incidents were usually reviewed by them every three to six months, but this process had been delayed recently. Learning from lessons was not shared by managers to ensure staff knew the best ways to help incidents and accidents happening again. A staff member told us they did not know what happened once incident forms were completed, and staff did not receive feedback from management about accidents and incidents that happened. Completed incident and accident forms had not all been reviewed by management. Where forms had been reviewed, they lacked detail about on-going actions being identified, or how people's welfare should be monitored to try and prevent issues re-occurring.

The provider had failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, ensure lessons were learnt or ensure staff had the right skills and experience to safely meet people's needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●During the first day of our inspection, when being made aware by our inspectors, the registered manager replaced the medicine storage fridge, purchased new water jugs with lids and cleaned the medicine storage room.
●After our inspection, the manager gave immediate assurances about actions being planned and taken by staff in partnership with other health and social care professionals regarding risk management and staffing issues we identified.

Systems and processes to safeguard people from the risk of abuse
●Since the last inspection there had been several whistleblowing and safeguarding alerts raised concerning people using the service by staff or partnership agencies. These included allegations of staff physical and psychological abuse and neglect against people.
●During this inspection we identified risks, issues and concerns relating to safety incidents and safeguarding that had either not been reported or had not been adequately acted on regarding people's constipation, aspiration and behaviours that may challenge.
●One staff member told us they knew the support staff were giving one person in the form of unauthorised and unmonitored isolation and physical and chemical intervention was improper treatment and staff had also been neglecting this person's needs for at least six weeks in their estimate. However, they and other staff and management had failed to raise a concern internally or externally, despite being aware of this and having regular contact with outside health and social care professionals about this person's support during this period.
●During our visit we observed staff supporting this person when they became frequently physically challenging by responding with unauthorised physical intervention, medicine administration and isolation. We observed the person was isolated alone for unagreed and arbitrary lengths of time with no means of stimulation, in a room that contained several environmental hazards. None of these interventions were being monitored by staff or management to check the person was safe.
●We received feedback from a healthcare professional who told us a person had recently left the service after their placement had broken down due to their repeat physical assaults towards other service users and staff. The professional raised concerns staff had neglected this person's needs and had not alerted external healthcare professionals to early incidents of aggressive behaviour until long after the events.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following our inspection visit CQC raised two independent safeguarding alerts with the local authority regarding people's needs being neglected and being subject to improper treatment with their behaviours that may challenge and constipation support. The local authority in partnership with staff and other health and social care professionals conducted further urgent site visits and began work to agree actions with staff to keep the people safe. We sought immediate assurances from the manager about how they were acting to reduce risks of abuse for people with behaviours that may challenge and constipation support needs.
●People we spoke and communicated with did not indicate they felt unsafe from abuse at the service. We saw some people appeared comfortable around staff. Relatives and some health and social care professionals told us they had not had any previous concerns about people being at risk of abuse at this

service.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Although some cleaning was taking place daily, the medicine room and other areas of the service were not being kept clean. Staff told us the medicine room had not been cleaned for at least four weeks. The provider acted on the first day of the visit to clean these areas and put in place a new cleaning schedule.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. Due to the needs of the people at the home social distancing was not always possible, although staff encouraged people to follow government guidance if possible.

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

● 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.

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

● 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.

●The provider facilitating visits to people living at the home in accordance with current guidance

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 where we inspected this key question, it 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 always holistically assessed to consider what people wanted and needed from their support. While we did not observe any overt or direct discrimination, staff told us they focused on assessing and delivering support that met people's healthcare needs and had not always considered people's social, mental and emotional needs or associated best practice guidance when delivering people's support. This included when people's needs had changed.

●For example, people using the service whose behaviours may challenge, including for people where these had recently increased in frequency and severity, staff had not acted to carry out a functional assessment of their behaviour support needs. Functional behavioural assessments are a holistic, collaborative process that look at the reasons behind an individual's challenging behaviour in depth. This assessment process is important to provide information to help plan how staff should respond to behaviours, based on the known function behind them, with the aim of promoting preventative and positive interventions from staff to help avoid the need for using reactive and restrictive practices. This enables people to have the opportunity to enhance their quality of life and learn new skills to replace the challenging behaviour.

● Where assessments of people's social needs had been carried out in partnership by social care professionals, we were told staff were not always aware of, or were following, their recommendations to deliver effective support for people. This had resulted in people experiencing a poor quality of life and being placed at risk of harm to their health and well-being. For example, one person had been supported by an Occupational Therapist to assess and identify sensory activities that could help meet their sensory and tactile needs and reduce their anxiety and physically challenging behaviours. Staff had not implemented these recommendations consistently and the person had continued to experience repeated episodes of anxiety and physically challenging behaviours.

Failure to assess and design care to ensure people's preferences are achieved and their needs are met is a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Technology and equipment were currently only being used by staff when supporting people with their physical and healthcare needs. The manager told us they were looking at sourcing technology to enhance the ability of people to communicate with others and help them to understand information. This would help people to become more socially empowered and independent.

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.

● The service was not always working within the principles of the MCA, and people were at risk of being unnecessarily restricted or receiving support that was not in their best interests. Staff did not always understand the relevant consent and decision-making requirements of this legislation.
●People's mental capacity to be able to make decisions about different activities had not always been assessed or regularly reviewed by staff. Where people had been provided with support when they were assessed as not being able to make certain decisions, the person with authority to act in their best interests had not always been identified and involved in agreeing this.
●Where renewals of DoLS authorisations were needed, these had not always been applied for or reviews requested for existing applications in a timely manner to re-assess and confirm their lack of ability to consent to their care arrangements. For example, five people had pending renewals for DoLS from 2015, three people had renewals pending from 2016 and one person had a review pending from 2017. Staff were continuing to subject people to constant supervision and they were not free to leave the service. This increased the risk that people may be being unlawfully restricted.
●People who were not subject to DoLS on the basis they had capacity to consent to the arrangements of their care were subject to continual supervision and were unable to leave the service or access the grounds without staff agreement. This decision to restrict people's liberty had not been assessed on an individual basis to evidence if the person had consented to this decision or that it was in their best interests.

Failure to ensure service users consent to care and treatment had been sought in accordance with legislation is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
●The provider was not ensuring staff had always received appropriate training to be able to meet people's needs effectively. Staff told us training they had received was not good enough for them to feel confident or know how to deliver effective care for people with behaviours that may challenge. We observed staff evidencing a lack of knowledge and skills and not following directions in people's support plans and risk assessments about how to effectively support people with behaviours that may challenge and activities, resulting in people become upset or distressed.
●The registered manager and staff told us, and staff training records showed staff had not received updates in training of relevant subjects to their role as per the provider's policy of refresher training. Staff had not received regular formal supervisions or appraisals. This increased the chance they would not know how, or have support to, enable them to support people to achieve good outcomes. Staff told us their inductions had not been of a good standard, or they had not received one. Some staff were unsure about the requirement of their roles or if they were competent when doing their jobs. One staff said "I am not sure about my role. I don't know what I am meant to be doing".

●Health and social care professionals who regularly worked with people and staff at the service told us they had concerns about the lack of skills and knowledge of staff and management, which they thought was contributing to people having bad support outcomes that impacted on their health and quality of life.

Failure to ensure staff had received appropriate support, training and personal development to carry out the duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

●Staff talked with and observed people's day to day health needs and had supported some people to make referrals to health care professionals where people had become unwell. Staff had arranged for some people to have support from independent advocate services to help them understand and make decisions about suggested healthcare treatments.

●We received mixed feedback from health and social care professionals about how well staff worked with them to make sure people received access and on-going support to healthcare. One professional told us, "(whenever we have given healthcare advice) the advice given appears to be followed by the staff". However, several other professionals told us healthcare information and advice they had shared with staff was not implemented recently. This had led to poor outcomes for people's health and quality of life.

●Staff were inconsistent in recording their formal monitoring of people's on-going healthcare needs, such as epilepsy and constipation. This could increase the chance people may not be supported to access healthcare services or that healthcare services would have accurate information about people's conditions to be able to provide appropriate support.

●Relatives told us they thought staff helped people to monitor their health effectively. One relative said, "If there's a problem they are on the phone to the doctor straight away".

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

●. We did not see people always being involved in making or being offered choices with food or drinks they were given by staff.

●Staff had sought advice from SaLT to help advise them about the people's specific dietary needs and develop eating and drinking guidelines. We received mixed feedback from health and social care professionals about how well staff understood and followed eating and drinking guidelines. During our inspection visit, staff were following SaLT guidelines regarding consistency of food and drink for the people with swallowing difficulties that we saw being supported at lunch.

●The chef told us the service could cater for any religious or cultural food preferences, if these were requested. People were supported to have meals in communal dining areas. When we observed lunch there was a busy atmosphere, without much social interaction. Most people appeared to enjoy their meals. Relatives did not raise any concerns about the quality of the food at the service. One relative said, "They have roast dinner on a Sunday -it smells nice".

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

● The premises was an old manor house that had been converted into a hotel and then a care home approximately forty years ago. The original premises had not been designed to accommodate people with physical and learning disability support needs and promote their independence, and since conversion into a care home the provider had not acted to ensure that appropriate modifications or structural alterations and additions had been made to meet the individual needs of the people who lived there .

● We observed it was not easy for people who used wheelchairs or people with mobility issues to navigate around the building independently. The service was set over several different floors, some of which had different levels within them, which were accessible only by stairs. There was only one staircase with a stair

lift, which people could only use with staff support. There were lengthy narrow doorways and corridors on all floors of the service, including those leading to the communal lounges and dining areas. People in a wheelchair and people walking could not use the same corridor or doorway at the same time without an increased risk of people falling or bumping into each other, and people were often obliged to go back on themselves to let the other pass. A relative told us, "It wasn't purpose built…the physical aspect of the service is challenging for people living there".

●Communal living areas were very large and had not been adapted or arranged to help better accommodate the diverse support needs of all twenty-eight people currently living at the service. For example, communal areas had not been adapted to help people take part in meaningful sensory or social activities, according to their needs.

●There were large private grounds, including a walled vegetable garden. People were not able to access these spaces without staff support, which was often limited, meaning people could often not go outside even if they wanted to. This arrangement had been implemented on the basis that all people might come to harm due to falling or from use of gardening tools, which were kept stored in a locked shed in one of the areas when not in use. This arrangement not been risk assessed on an individual basis to check it was proportionate or necessary for all people to need staff support to remain safe if they went outside. Staff had not adapted the access or design of the gardens to enable people to take part in activities that used the outdoor areas , with or without staff support.

●There was a small outbuilding in the service grounds referred to as a 'day centre'. We did not visit this area during our inspection. The manager told us, "People can see visitors there and some people will go to the day centre independently. It is used as a hairdressing salon and there is a kitchen area, computer, television and settee". A relative told us, "The day room where they do the art needs a tidy up and was cold when we went there".

●All people shared communal bathrooms, which were in the process of being adapted to better ensure people's individual needs were met. People had decorated their individual bedrooms according to their preferences. Three people who preferred a more relaxed atmosphere had been allocated rooms on the top floor of the service, where it was quieter and less busy.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity, Supporting people to express their views and be involved in making decisions about their care, Respecting and promoting people's privacy, dignity and independence

●People were not always treated with kindness or compassion, which impacted negatively on people's quality of life and emotional well-being. We observed several occasions where people were ignored and not responded to quickly or at all by staff when showing signs of impatience and distress. This caused other people who were in the same room and people in the immediate area to also become upset.

●There had been instances since the last inspection where staff had raised concerns that other staff did not speak or treat people in a kind or caring manner. We observed staff speaking to people using infantile language. Staff were seen becoming impatient and speaking in a disrespectful tone of voice to people who were asking them questions about their support, telling them to wait until staff had finished what they were doing.

● People were not always given information, involved in making decisions about their care or supported to express their views. We observed several instances over the course of the inspection where staff moved people in their wheelchairs without asking permission or explaining what was happening. People were told to go and sit down and be served meals without asking their permission.

●On another occasion, staff entered the lounge and told people they would now play a game. The game was set up and begun without staff asking anyone if they wanted to play. People did not engage with the game, appeared bored, fell asleep or attempted to leave. Staff continued to play the game by themselves and asked people who were attempting to leave to stay.

●People were not always supported to be as independent as they wanted. Twice a day staff bought round a trolley and started giving people drinks without talking to them at all or asking what they wanted. When people came up to the drinks trolley, they were told to go and sit down and wait their turn to be brought a drink. On one occasion staff poured a drink for a person, spilling it onto the table they were sitting at. The person could not wipe up the spillage without help. Staff did not wipe the drink up for some time, until after they had finished serving other people in different parts of the room.

●There was a separate kitchen downstairs for use of the whole service. All service users were not allowed to enter the kitchen alone. This had not been assessed on an individual basis. The kitchen had not been adapted or designed to support people who were able to be involved in preparing their own meals and drinks day to day.

Failure to ensure people were always treated with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We observed other staff who appeared to know people well and interacted with them in caring manner,

speaking to them in a kind way and asking them about how they wanted to be supported. Relatives told us they thought staff knew people well. One relative told us how staff always respected their family member's choice about what they liked to wear. A healthcare professional told us, "We have observed the staff being courteous and polite to residents".

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 requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences, Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Staff told us management wrote care plans and people and other staff were not formally involved in this process. The lack of involvement of people, or relevant people in their life when contributing to the planning of their care reduced the amount of choice and control people had over the delivery of their support. People's care plans lacked information and details regarding their emotional and social needs as well as their strengths and levels of independence. Care plans had not always been reviewed as often as the provider's preview policy indicated they should be. This increased the risk that staff may be neglecting or not responding in the best way to people's individual wants and needs, affecting their overall quality of life.

●Staff told us they had not always read everyone's care plans and they mainly relied on sharing informal knowledge, verbal handovers and updates to know how to support people's needs. This increased the chance information may not be available or that staff may not know how to best respond to people's needs to deliver personalised support. This chance was increased as a lot of agency staff worked at the service who did not know people well.

●People were not being supported to regularly identify, or review, on-going individual aspirations and life goals. One staff said goal and care planning "Isn't something we do a lot of. Most people aren't interested". We were told by staff they did not think people received person-centred care at the service, due to staff not having time to do much more than support people with basic personal care and nutrition needs.

●People did not have support to follow their interests and take part in appropriate social activities. Staff, relatives and professionals all told us this was an issue that was negatively impacting on people's quality of life and well-being.

●Many people had stopped going to outside educational and activity centres or visiting the community during the COVID-19 lockdowns. Staff had not acted to make sure people's social needs and interests were fulfilled during the lockdowns or since restrictions had been eased and lifted. One staff told us, "There is no activities coordinator, with the shortage of staff activities are bottom of the list. Sometimes we might do some activities on a whim".

● We observed people spent large periods of time doing nothing during our visits. When people were provided with 1:1 and group-based activity support, this did not always reflect their individual needs and choices as recorded in their care plans and risk assessments. People's care records showed they were not leaving the service or being offered any activities apart from meals, personal care and watching television for long periods each month.

●Professionals had raised repeated serious concerns about people's support lacking structure and meaningful activity, resulting in people "experiencing aggressive outbursts and assaulting staff and peers".

One professional told us, "I think it should be noted that this problem had been an issue since the start of the covid crisis in early 2020, and staff had not acted to fill these empty days with activities".
●Another professional said, "With regards to activities and engagement with clients, this is lacking. The home don't feel that they need individualised activity planning this is the way it has always been. When we have asked for this for people it was not implemented".

The provider was not ensuring people received person-centred care. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

●Staff did not always communicate in accessible ways with people. One person had pictorial aids, to help them engage and understand when communicating with staff. However, throughout the inspection we did not see staff using these when communicating with them. People's care plans were only available in written format, although most people could not read the information in them when presented like this. The manager told us they were re-designing and writing care plans and AIS would be considered as part of this process
●Staff had begun to explore using other forms of accessible communication with people, such as Makaton which is a type of sign language. The registered manager told us progress had been delayed due to lack of training courses being available during the pandemic.

Improving care quality in response to complaints or concerns
● The registered manager told us there was a complaints folder where any concerns were logged and responded to a soon as possible. Planned regular people and staff meetings were not currently occurring regularly or at all and there was a lack of formal process for people to be able to raise a complaint about the service directly. It was not evident from our observations of staff interactions with people that they would always encourage or support people to raise a complaint if they were not happy about their care.
●Relatives did not tell us they were aware of a formal complaints policy but told us they knew they could contact staff if they needed to complain. Relatives told us they were confident staff would deal with any complaints fairly.

End of life care and support
●No one at the service was currently being supported with end of life care. People had been supported to consider advance care planning, to make sure they got the right support, resources and equipment to have as dignified and pain free a death as possible. People had been supported to make decisions about if they wanted cardiopulmonary resuscitation or not if they became seriously unwell.

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

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

● At the last inspection in July 2021 we found evidence to support a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance as the provider was failing to operate effective systems and processes to assess and monitor the service. We had also identified a breach of CQC Registration Regulations 2009 Regulation 18 as the provider had failed to report abuse or allegations of abuse to CQC without delay.

●At this inspection, not enough improvement had been made or sustained and the service remained in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 . The continued breaches and deterioration of quality and safety had left people exposed to potentially high risks of harm and poor-quality support and evidences a lack of continual improving care.

●There were minimal internal quality assurance systems and processes to audit or review service performance and the safety and quality of care. Where checks and audits were carried out, they had not always identified or prevented issues occurring or continuing at the service. For example, medicine audits had not identified issues we found during this inspection. Where issues had been identified, the registered manager and provider had not always effectively overseen or ensured actions were taken to maintain or improve the quality and safety of the support being delivered at the service. For example, audits of DoLS and cleaning had identified issues we found during this inspection, but no action had been taken to help resolve these issues.

●Internal systems of staff and management appraisals and supervisions were not operating to help staff to understand and fulfil their responsibilities and support staff to be positively accountable for their performance. Staff at all levels within the organisation told us their performance was not managed well and they were not always clear about what good care looked like. Several staff said they did not feel they were able to fulfil all their duties to a good or safe standard. Various staff said they had made their immediate manager know about this but there had been no support offered to them or responsibility taken on any levels to further understand and resolve the issues.

●Following our visit to the service, the registered manager resigned with immediate effect effect to take up a care co-ordinator role at the service. The service is currently without a registered manager and the managing director is acting as service manager until a new registered manager can be recruited.

● People did not always have an accurate and contemporaneous record of their care in place. Despite re-writes and reviews by the head of care and registered manager, people's care plans, risk assessments and monitoring records in relation to medicines, behaviour, aspiration, constipation and social support needs were not always accurate, complete or up to date.

●Relevant legal requirements, including CQC registration requirements had not always been met. Social care services are required to notify the CQC of important events that happen in the service and about the support they provide. This is so we can check the action the provider takes and ask for more information if we need it. We found statutory notifications had not always been submitted as required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics,

●Staff and management were not able to identify a clear vision or set of values about the support people should receive or tell us how they should demonstrate them when carrying out their roles. One staff said, "they're written on the wall somewhere, but I can't remember what they are".

●Staff at all levels and the provider were not able to demonstrate they had an up to date knowledge or understanding of the expectations contained within the guidance CQC follows 'Right support, right care, right culture' about the support people with a learning disability and autistic people should receive. People were not receiving support that guaranteed them respect, equality, dignity, choices and independence and good access to local communities that most people take for granted.

●Staff and management at all levels spoke of a negative and closed culture within the staff team, which affected staff morale and allowed quality and safety issues to remain unresolved. One staff said, "There are cultural reasons why things that aren't right don't get changed, I don't want to say any more than this". Another staff said there were issues with bullying within the staff team that management knew about, but not enough had been done to resolve the issue which was still going on.

●There were not regular staff meetings to allow all staff to get together to discuss issues and ideas about how to develop the service openly. One staff said if any issues were raised about the way the team worked, this was dealt with by management on a 1:1 basis and there was no further feedback or changes everyone was aware of. They said when they had raised issues about improving the service, these had not been acted on.

●There were no system for people either individually or in groups to gain their input in how the service was being delivered or how it could be improved. The registered manager said, "We used to but they weren't really getting anything from them". They added, "We are trying to get back to 'my voice' with smaller groups - where we speak to residents" but this had not been done and there was no plan about when this might happen.

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, Working in partnership with others

● Recommendations and actions identified by partnership agencies regarding people's support needs had not always been implemented or consistently followed to ensure people achieved good outcomes. Health and social care professionals told us about several examples where staff had not acted to follow advice and directions in care plans they had developed alongside staff, resulting in avoidable situations where people had to move out of the service as staff could not meet their needs or keep them safe.

● Safety incidents relating to neglect, unsafe care and service users being harmed whilst receiving support with regulated activities had been reoccurring regularly at the service since the last inspection. These incidents had not always been reported to internally or to external agencies openly and in a transparent way, or at all to ensure there was an adequately informed review, investigation and actions agreed to help avoid or prevent these issues happening again. Staff and management could not explain the reasons for this or told us this was because they "had forgot".

The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately

maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●Following the inspection, we asked for and received immediate assurances from the manager about how they would act to reduce serious risks to people. The manager told us they were committed to making improvements to address all issues identified during the inspection and the provider was willing to invest resources to allow them to do so. They said they were unaware of the extent of the issues and, "This is not support or a culture that I would want for people. I know there should have been better leadership input".

●The local authority and CCG learning disability teams provided feedback about on-going and immediate support they were planning to provide for staff and management to help address quality and safety issues. Initial feedback from professionals was that staff and management were willing to acknowledge issues and engage with their teams to help resolve issues.

●Prior to and during the inspection we identified the provider was not displaying their CQC rating on their website or displaying the correct CQC rating in the service, which is a breach of the requirements of Health and Social Care Act 2008 (Regulated Activities) 2014 Regulation 20A: Requirement as to display of performance assessments. The provider acknowledged this failure as an oversight on their part and acted to immediately rectify this breach.

●The provider had an Equality and diversity policy in place to ensure staff were not discriminated against. They had made workplace adjustments to allow staff to work around health and childcare needs. Staff told us although morale was bad and some staff within the team did not get on, they felt sure problems between staff were not caused or being driven by discrimination against anyone's protected characteristics under the Equality Act 2010.

●The relatives we spoke with were positive about the management and how the service was being led. One relative said they had been sent newsletters about twice a year and felt in touch with what was going on at the service. Another relative said they found staff and the manager were approachable and, "If there is an issue, we can talk about it with them".

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure service users consent to care and treatment had been sought in accordance with legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had received appropriate support, training and personal development to carry out the duties they are employed to perform.