Aston Care Limited

The Paddocks

Inspection report

493A Semington Road
Melksham
SN12 6DX

Tel: 07714244273
Website: www.astoncarehomes.co.uk

Date of inspection visit:
25 May 2022
29 May 2022
07 June 2022

Date of publication:
01 September 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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
The Paddocks is a residential care home providing personal care without nursing for up to five people with a learning disability and/or autistic people. At the time five people were living at the home. One was in a self-contained flat in an annex to the house. Another person had a living space as well as a bedroom and bathroom. Some people at the service had limited verbal communication or communication difficulties.

People's experience of using this service and what we found
Right Support
People were not always being supported by staff who had received enough training to keep them safe and meeting their needs. Care plans were not always personalised and lacked guidance for staff to provide consistent support. Systems were not in place to support those who lacked verbal communication to make choices. The national staff crisis was placing an impact on people living fulfilled and rich lives. Staff were not recognising or acting proactively to support people who became distressed, anxious and/or upset.

Current best practice, guidance and legislation was not always being applied when staff were providing support to people. This had not been identified by the management systems. The safety of the environment lacked effective oversight by the management to make sure it was keeping people safe. Although improvements had occurred around fire safety since the last inspection.

People were supported safely to manage their medicines and improvements had been made since the last inspection. Staff supported people to participate in a range of activities which was in line with their wishes. Links with other health and social professionals was positive although timely referrals had not always been made.

Right Care
People's care and support plans were not always personalised especially for those newer to the home. Staff and the management had not explored a range of communication strategies for those who did not verbally communicate. No end of life plans in line with people's needs and wishes were in place. Staff and the management we spoke with lacked understanding of the legislation around making choices for people who lacked capacity and/or had fluctuating capacity.

Not all risks were assessed for people which placed them at risk of potential harm or inconsistent care. The management had not effectively assessed people knew to the home to consider how compatible they were.

Also, that all their personalised care needs were in place prior to them moving in.

The registered manager promoted equality and diversity in the support for people and led by example. Most of the time people's privacy and dignity was respected.

Right culture
People were not always receiving care which empowered them. Quality assurance systems were not effectively picking up concerns found during the inspection. The registered manager wanted to drive improvement although systems were not always in place to allow this to happen. There was a lack of staffing structure at the home to promote high quality, positive support for people.

Staff were generally compassionate and not task focussed. People had advocates and those important to them were involved in their care and support. Informal systems were in place to hear feedback and for people to raise concerns. These were not always being documented to learn from. People who were able to express their views were listened to.

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
This service was registered with us on 9 May 2019 and this is the first comprehensive inspection leading to an overall rating and rating in each domain. The last focussed inspection looking at safe and well led was published on 17 April 2021 and there was no overall rating. At this inspection the service is now rated requires improvement.

At the last inspection two breaches of regulations were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made in the areas of concern. However, new concerns were identified, and the provider is still in breach of the regulations.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture and follow up concerns from the previous 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.

Enforcement and Recommendations
We have identified breaches in relation to keeping people safe from potential abuse including restrictive practices, mitigating risks to people, making decisions for people who lack capacity and/or have fluctuating capacity, lack of staff training and management of the home at this inspection.

We have warned the provider to make improvements around governance systems and will be following this up in three months to make sure improvements have happened. For all other breaches please see the end of the report for the actions we have asked the provider to take.

We have also made recommendations around recruitment of staff and end of life care.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The Paddocks

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
Two Inspectors and a member of the CQC medicines team completed on site activity. During the inspection an Expert by Experience carried out phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Paddocks 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. The Paddocks is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information on our

systems. We used all this information to plan our inspection.

During the inspection
We communicated with five people who used the service and two relatives about their experience of the care provided. We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with one person to tell us their experience. The person chose not to engage with us using this method.

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 used the information the provider sent us in the provider information return (PIR) which arrived during the inspection. 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 spoke with six members of staff including the nominated individual and registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included four people's care records and three people's medication records and related care records. We looked at two 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three health and social care professionals.

Requires Improvement

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 focussed inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Systems were not in place to safeguard people from the risk of potential abuse. Four people communicated at times by becoming upset and distressed according to their care plan. No staff had received training on how to proactively support someone to decrease their distress and understand what they were trying to communicate. There was limited or no guidance in care plans informing staff on what the communication might mean and how to respond leading to a positive quality of life.
- One person who recently moved in had clear guidance from a previous placement and staff failed to recognise them getting upset. Another person who lived at the home stepped in to check if the distressed person was alright.
- Incidents and near misses were not being recorded prior to the current registered manager starting. This meant there was a risk people had been subjected to potential abuse and there had been no oversight by the provider. On another occasion an untrained staff member had used a physical restraint in an emergency. No records existed or debrief to determine if this was the least restrictive and unavoidable placing people at risk of inappropriate restraints and to prevent a reoccurrence.
- Only three out of nine staff working at the home had in date safeguarding training. Staff were able to name some ways abuse could be recognised from previous places of work. The registered manager lacked manager level training and was not familiar with the process of raising an alert. Neither were they able to talk us through their responsibilities around safeguarding.
- The provider's policies around restrictive practices when someone became distressed, frustrated or upset lacked detail. They did not specify named restraints that should be trained and used. Neither had the provider recognised the safety aspects of using certain restraints listed in the policy. Wording used meant it could easily be misinterpreted by staff. The registered manager looked at them with us and was not clear on accepted and trained restraints the provider recognised. This placed people at risk of untrained staff using an inappropriate and potentially dangerous restraints in an emergency.

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.

- During the inspection, we raised a safeguarding with the local authority in relation to some concerns around one person's safety.
- People were comfortable in the presence of staff when they were being supported. One person expressed they felt safe at the home. They continued staff come and help when they were asked. One relative told us their family member was, "In a good place", was "Well impressed" and, "Staff are very good."

Using medicines safely

At our last inspection systems were either not in place or robust enough to demonstrate medicines were effectively managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection around medicines. However, the provider was still in breach of regulation 12 in other areas.

● Improvements were required in how 'as required' medicines effectiveness was monitored once they had been administered. This was to facilitate a more person-centred planning of care. Following the inspection, the registered manager improved this.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles
● People received support from staff to make their own decisions about medicines wherever possible.
● Staff made sure people received information about medicines in a way they could understand.
● Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating, and when assessing risks of people taking medicines themselves.
● Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.
● People were supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely.

Assessing risk, safety monitoring and management
● People were not always being kept safe and having their risks managed when they had recently moved into the home. Two people which had moved into the home since January 2022 had only 'Initial short-term support plans' in place. There was also no, or limited risk assessments completed as part of this.
● One person's initial support plan lacked key information regarding risk of choking, aspirating and having a seizure when unwell. Staff were unfamiliar with them and how they presented when well and not well which meant there wasn't clear guidance for staff to follow A risk assessment from a previous placement for eating and drinking by a speech and language therapist had changed and staff were not aware as they only had access to an out of date plan. The registered manager rectified this during the inspection.
● Another person required hoisting for transfers between the floor, their bed and a chair. The only risk assessment and guidance in place was for when the person was having intimate care and the transfers involved with this. During the inspection they were moved from the floor to an armchair. On another occasion from an armchair to a wheelchair. By not having clear risk assessment there was a risk of inconsistent care and harm.
● People were at risk of harm around some environmental risks. No recent water test had been completed to check for legionnaires disease to protect people. Following the inspection, the registered manager told us it was completed the previous year and one was now due which has been organised. There were uncovered radiators including in people's bathrooms where people were more likely to slip. The nominated individual accepted this as a risk and said they would rectify it.
● Staff lived or stayed at the home between working shifts. The registered manager told us there was no risk assessments in place to keep people safe in relation to this decision. For example, to protect people from potential unauthorised visitors.

People were not always receiving safe care and treatment that managed risks well. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager explained they had struggled to keep up with the work related to the new admissions. They took on board everything we said and already were taking actions during the inspection.
● People who had lived at the home for longer had a wide range of risk assessments. This included those that covered how to support them in times of distress, with mobility and accessing the community. Staff were familiar with these.

Staffing and recruitment
● People were supported by staff who had criminal record checks and references from previous employers. However, some references had no evidence they were from previous employers and one member of staff did not have a full employment history. The registered manager was not aware of the legislation around safely recruiting staff and checking they were of good character. They assured us they would change their practices in future.

We recommend the management update their knowledge around safely recruiting staff in line with current legislation and update their practices accordingly.

● People were supported by enough staff to keep them safe. Most of the time the staff supported them to meet their needs and wishes. However, from time to time to ensure that safe staffing levels were met one-to-one time with people was compromised.
● However, the allocation of staff seen during our inspection did not always appear to consider the impact on a person's quality of life. For example, some staff prioritised spending time completing tasks such as cooking in the kitchen without people, rather than including people so they could participate in cooking.

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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.

Learning lessons when things go wrong
● Systems were being developed by the registered manager to learn lessons when things went wrong. People's care plans were starting to be updated when a person's needs changed and shared at staff meetings. For example, one person did not like being comforted in a certain way due to past events. Their plan now reflected this information and staff were aware of it.
● However, the systems were not consistently applied to all accidents and incidents. Also, the registered manager did not have a system to ensure that, where changes to people's care had been identified, staff were implementing these changes.

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.

This is the first inspection of this domain for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

- People who lacked capacity or had fluctuating capacity were not always supported by staff and a registered manager who understood how to do this in line with statutory guidance. No capacity assessments were completed for restrictive practices such as locked doors around the home. There was no evidence that these were the least restrictive options and, in each person's, best interests.
- One person who recently moved into the home lacked capacity or had fluctuating capacity for most key decisions such as medicines, accessing the community and intimate care. There were no capacity assessments or best interest decisions in place.
- A second person who moved into the home in January 2022 also lacked capacity had minimal capacity assessments and best interests in their care plan. There was a document titled 'Consent to care and treatment' that stated there should be a capacity assessment and best interest if a person lacked capacity. This had not been done for this person.

Systems were not in place to ensure consent for care and treatment for people who lacked capacity and/or had fluctuating capacity was in line with legislation. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People who lacked capacity were not always having their liberty restricted in line with current legislation. The service had locks on many doors including bedrooms and the kitchen door which was not documented

within people's DoLS. While one person had decided they wanted to lock their bedroom door, other people did not have the capacity to decide. The registered manager had not recognised these are restrictions of people's liberty.
● Some conditions on peoples' DoLS had not been met. For example, a lack of attempts to increase opportunities for one person to interact with other people to enrich their quality of life.
● One person who had recently moved into the home had no DoLS applied for and the registered manager confirmed this. Another person had a three-month delay to a DoLS application being made when they moved in.

Systems had not been effective to ensure people's liberty was restricted in line with legislation. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People were not supported by staff who had received training to keep them safe and meet their needs. Staff told us they felt they required more training although were doing their best to deliver support to people. The registered manager explained when preparing information for the inspection they recognised this.
● No staff had received training in how to support people who could become upset, frustrated and anxious. People were seen becoming anxious and upset during the inspection without staff proactively recognising this. Other people could potentially hurt themselves or staff according to their records. Staff did their best to keep people calm and support them in a positive way with the limited knowledge they had.
● Staff were not being put on essential training prior to new people moving into the home. Examples were seen around recognising seizures, falls awareness and supporting people with incontinence. This placed people at risk of potential harm.
● People who had lived in the home for a long time were being supported by staff who lacked training in key areas. For example, only one member of staff had completed mental health training and only three staff had completed autism awareness training. Some staff were using experience and training from other places they had worked.
● Agency staff working in the home were not receiving any induction to familiarise them with people or the home and systems. There was reliance on staff telling them about people and their needs.

Systems were not in place to ensure people were supported by staff who had received training to meet their needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff completed an induction and the Care Certificate. The Care Certificate is a set of standards that all staff in health and social care should have. They also shadowed experienced staff and had reviews with the registered manager.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People new to the home were not having their needs being reviewed effectively to ensure they had their support, health and wishes followed by staff. One person had recently moved into the service. Key pieces of information had been missed by the management which placed them at risk of harm and poor care. For example, one person required a specialist diet which was not recognised at the transfer of care. This resulted in the person receiving the wrong type of diet. During and following the inspection the registered manager worked hard to rectify this.
● People who had been in the home longer who had changing needs had these reviewed in line with their needs and choices. One person had expressed they wanted to go back to college. This was being

investigated.
● The management had a lack of knowledge and understanding around current standards, guidance and the law. Examples were found around lack of specialist training for staff and poor knowledge about the registered manager's familiarity with the regulations and guidance they should be following.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to choose where they ate and what they ate. One person told us they were going to have hot dogs later and when the next meal came this is what they had. Another person was happy on the sofa and so their food was brought to them whilst they watched television. Although daily records for one person did not provide information which demonstrated a range of fruit and vegetables was offered. Other people were seen eating salad with some of their meals.
● A third person had previously completed a cooking course in college. They were pleased to show us baking they had done recently and photos of the food from the course. Not only did they cook for people they also cooked for the pet chickens.
● We observed people being offered choices of drinks throughout the inspection. One staff member told us, "Here it is very person-led. As long as it is not going to harm them, we always ask them what they want for lunch or dinner. If it is not in the house, we explain this, or we try to get it for them."
● However, there was a lack of staff involving people in the preparation of their food in the main house. Or ways for people who had limited verbal communication to express any form of choice using alternative methods.

Adapting service, design, decoration to meet people's needs
● People were living in an environment that the provider had tried to create a homely feeling. Two people had self-contained flats to promote more independence. In the lounge there was a pool table and multiple sofas people could relax on and spaced out.
● There was work being completed on the outside area including creating a vegetable patch and having chickens. Raised flower beds had been purchased so those in wheelchairs or unable to bend could also be involved.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had been supported to see doctors when their health declined and expressed, they were feeling unwell. Examples were seen of people who had contact from multiple health and social care staff.
● The registered manager demonstrated their willingness to work with other health and social care professionals during and after the inspection. Including providing regular updates on progress which had been made. They had a good working relationship with the local pharmacist.
● Staff did not always make appropriate referrals to other health and social care professionals. Such as when people were admitted ensuring everything was in place. However, when this was highlighted to the registered manager, action was promptly taken.
● People lacked hospital passports to be used in the event of an emergency transfer. A hospital passport contains all the key information which would be required such as medicine, communication and mobility needs.

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.

This is the first inspection this domain has been reviewed of this newly registered service. This key question has been rated requires improvement. This meant people were not always supported to independence despite generally being well-supported, cared for or treated with dignity and respect.

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

- People felt listened to and valued by staff. Two people told us they liked staff and a third felt they could speak with staff if it was needed.
- People were given time to listen, process information and respond to staff and other professionals. When staff went around asking what people would like to eat then most gave options and time to people for making their choice.
- However, staff did not have training or access to methods people could use to communicate choices for themselves. Only three staff had completed their training in line with this. Two people at the service did not verbally communicate and no alternative methods were seen being used.
- People were supported to access independent, good quality advocacy. Two people already had advocacy in place.
- Staff supported people to maintain links with those that are important to them. One person's family member visited them regularly. The relative explained during the COVID-19 pandemic they received regular phone calls from the service and their family member. It provided them with, "Good feedback."

Respecting and promoting people's privacy, dignity and independence

- People did not always have the opportunity to try new experiences, develop new skills and gain independence. Locked doors throughout the home was not encouraging people to freely move around the home. One person's daily log stated the person who lacked capacity had attempted to go several times in the kitchen while staff were cooking. Rather than involving them in learning cooking and kitchen skills, staff redirected them and kept them away from the kitchen. It was not clear this was in their best interest and the least restrictive practice.
- People did not have plans in place which demonstrated how people would be supported to develop independence, aspirations and goals.
- Staff did not always know when people needed their space and privacy. One person was able to leave the main building and go to their self-contained flat when they chose. However, another person new to the service was potentially indicating they may want time to themselves. Instead of considering what they might be asking for the staff member told us that their behaviour was "Just a habit." There was no information in their care plan to confirm this and no options had been given.

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

- Most staff were calm and attentive to people's emotions and support needs such as sensory sensitivities. Staff respected one person wearing ear defenders because they could be distressed with loud sounds.

Although staff lacked recognition when the situation in the room became overwhelming for the person.

● People received kind and compassionate care from staff who used positive, respectful language which people understood and responded well to. However, there were occasions when staff prioritised completing tasks before people. This was observed by some staff not frequently leaving the kitchen.

● People felt valued by staff who showed genuine interest in their well-being and quality of life. Staff would have caring banter involving the people if this was their choice. One person liked to joke about things which had not happened. Staff recognised this and turned it into positive interaction.

● Staff members showed warmth and respect when interacting with people. One relative explained this was what they witnessed during their regular visits to the home. They said, "Staff are very good and now they have got to know [their] likes and dislikes and what [they] like to hear."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection this domain has been reviewed of this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met or reflected in guidance for staff to ensure consistent support.

End of life care and support

● End of life care had not been considered for people to ensure it was personalised and in line with their wishes. There was an aging population at the home.

We recommend that the management look into current best practice and guidance around end of life planning for autistic people and people with disabilities and then apply it to their practice.

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.

● People had not had their individual communication needs explored and staff lacked training in this area. Two people who lacked verbal communication had no alternative communication systems in place. Only three staff had completed the communication training.
● Care plans were currently not accessible for people to participate in them. One relative told us they had been consulted about their family members needs and complemented staff on how well they knew how to speak with them.

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

● People's care plans were not always personalised needs and wishes to provide guidance and consistency from staff. Two people who had moved into the home during 2022 lacked fully completed plans. There was little information about likes and dislikes the people had or strengths and weaknesses to ensure a quality of life.
● People who had lived at the home longer had more personalised plans with guidance for staff to follow leading to a positive quality of life.
● Support was updated when recent recorded incidents had occurred, and staff were provided with new information. People's outcomes were starting to be monitored and adapted as a person went through their life.
● People had not always had their goals and aspirations considered and their care plans lacked information about this long-term planning. Some staff and the registered manager were able to inform us on progress

people had made. One person had started talking about returning to college and the registered manager had already started investigating this request.

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

● Animal therapy had been considered by the provider and registered manager. People were able to have pets including a cat and a dog. There were house chickens and currently some eggs had hatched and had an area in the lounge. One person spent time telling us how much they loved the animals in the home. Another person animatedly told us about their cat.

● Support in the community was encouraged now that the government had eased the guidelines around COVID-19. People went out to the shops and for drives including stopping at cafes for a drink. However, there were some limitations due to low staffing levels at times which were caused by the national staffing crisis and lack of leadership during shifts.

● People were supported to maintain contact with families. During the inspection, one person's relatives came to take the person out and staff supported them to get the person ready. Another person had a relative visit which was a regular thing.

Improving care quality in response to complaints or concerns

● Systems were in place to manage complaints. The registered manager told us they had not received any complaints since they had started.

● Relatives told us they had no complaints although were not sure how to raise them. They knew they could speak with the registered manager who was approachable or the owner.

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

At our last inspection systems were either not in place or robust enough to demonstrate people were kept safe in the event of a fire. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection around fire safety. However, the provider was still in breach of regulation 17 because systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

● People were not living in a home that was well managed by the leadership team to ensure safe care and treatment with positive quality of life outcomes were achieved. The registered manager lacked a staffing structure in the home to support the daily running of the service. No formal system was in place to run shifts and the registered manager told us they were overwhelmed with the work that was required with a lack of support from a senior team in the home. This had led to incomplete, missing or delays in records being completed.
● Wide ranging concerns were identified during the inspection which had not been recognised by the registered manager or provider. This led to multiple breaches in regulations. For example, staff training had been limited, environmental risks were not identified, people were not kept safe from potential abuse and capacity and consent guidance and legislation for people who lacked capacity had not been followed.
● The registered manager told us they lacked a background in working with people who had a learning disability and/or were autistic. They demonstrated shortfalls in their own knowledge throughout the inspection. For example, questions to ask when assessing someone to see if the service was a suitable place to live and understanding of practices which could be classed as restrictive.
● Statutory notifications had not been sent in line with current legislation. A statutory notification is certain events that have to be notified to CQC. This meant external bodies would not be able to monitor care and support being delivered in a service. Two DoLS had been authorised and no notifications sent to CQC.
● People had been subjected to restrictive practices with no formal monitoring process by the management and a lack of understanding. The registered manager and nominated individual had not recognised the locks on doors were a restrictive practice. People were trying to enter rooms such as the kitchen and no

consideration as to whether the lock was in a person's best interest or the least restrictive practice.
● Quality assurance systems were not identifying concerns found during the inspection. The provider lacked oversight and audits of the service. For example, no one had recognised the legionnaires testing was overdue and most staff training was incomplete.
● The management had a reliance on external bodies recognising shortfalls which were required at the service. Medicines and risks around fire had been completed since the inspection in February 2021. However, further improvements were identified throughout the service which their systems had not recognised.
● 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, National Institute for Clinical Guidance (NICE) and the Autism Act 2009.

Systems continued to not be established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout the inspection the registered manager was open and clearly wanted to drive improvement at the service. During and following the inspection they were regularly updating us on positive actions they had taken to mitigate risks to people to keep them safe. This was often in conjunction with other health and social care professionals.
● People clearly had a positive relationship with the registered manager. Some were asking after them and the registered manager was seen interacting in a kind and caring way with people. One relative said, "[Registered manager] has been really good. I am well impressed." They also commented on the nominated individual and said, "The owner's number one thought is the people."
● Staff echoed the positive feedback we received about the registered manager. Comments included "[Registered manager] is absolutely top draw" and, "[registered manager] gets stuck in and is hands on".

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 knew their duty to be open and honest when things went wrong. They explained examples to us where this had happened. Again, they demonstrated it throughout the inspection. One relative explained when there was a COVID-19 outbreak they were kept informed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were being regularly engaged in the care they received if they were able to verbalise what they would like. One person was being supported to live a semi-independent life and could control how much support they received in their flat. However, those who had a limited amount of verbal communication lacked systems to contribute their feedback.
● Relatives felt engaged with the care and support which was being delivered and felt they could provide their views when it was required. One relative explained they had been involved in the initial placement at the home. They knew they could go to the registered manager or nominated individual at any time they wanted.

Working in partnership with others
● During and after the inspection the registered manager demonstrated their willingness to work with other health and social care professionals. They clearly had developed positive relationships with them. However, there had been occasions when it had not been recognised by the staff or management to get others

involved in a timely way. For example, when someone had moved in who could become distressed and potentially harm themselves a referral had not been made for specialist guidance.

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 Systems were not in place to ensure people who lacked capacity and/or had fluctuating capacity had decisions made in line with current legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 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 Systems were not ensuring people were protected from potential abuse including around the use of restrictive practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not ensuring people were supported by staff who were trained to meet their needs and keep them safe.

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 17 HSCA RA Regulations 2014 Good governance Systems continued to not be established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

The enforcement action we took:

We have warned the provider to resolve the concerns within three months and we will follow up and check this has been done.