Strode Park Foundation For People With Disabilities

Strode Park House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Strode Park is a residential home providing personal and nursing care to up to 55 people. The service supports people with physical disabilities and provides long term residential or nursing care, respite care and neurorehabilitation and supports people with a learning disability. At the time of our inspection there were 52 people using the service. There were four separate wings within the service, New wing, Basil Jones wing, Rees wing and Patton wing and each had adapted facilities to support people.

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

Right Support:
The service did not support the model of care setting. The service supported 52 people at the time of inspection, some people who had a learning disability and/or autistic people. The service is larger than the guidance recommends for a service that supports people who have a learning disability and /or autistic. The service is also located on a site with other care services, rather than people being supported to live in smaller homes in the community. This is to ensure people are receiving the person-centred support they need. Staff did not support people with their medicines in a way that promoted their independence and achieved the best possible health outcome. For example, when people were prescribed 'when required' restrictive medicines to help with anxious and distressed behaviours, there was no guidelines in place to inform staff when and why they needed to be used. These were being given regularly with no detail as to why they were given.

People were not always 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. People told us they were not always supported as they preferred. Staff did not consistently support people to take part in activities and pursue their interests in their local area and to interact online with people who had shared interests. Staff, people and their relatives told us there was not enough activities for them to do.

Right Care:
The service did not always have enough appropriately skilled staff to meet people's needs and to keep them safe. Staff did not consistently protect and respect dignity. People told us of occasions where their dignity had not been respected and staff had not always supported them with person centred care. Some people told us that staff were caring but there just wasn't enough staff to support with all their needs. We observed

Staff respecting people's privacy.

Right Culture:
People did not consistently receive good quality care, support and treatment. Staff had not always undertaken training for people's specific health concerns such as PEG care and emergency medicines for epilepsy. The culture of the service did not always enable staff to continuously learn and improve. For example, lessons learned from incidents were not always shared with staff to prevent similar events from happening again. Some people told us they were not always supported to lead empowered and inclusive lives, one person told us they felt institutionalised.

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

Rating at last inspection
The last rating for this service was good (published 13 October 2017).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and medicines management in the service. A decision was made for us to inspect earlier than planned to examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report.
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 of regulation in relation to the safe management of medicines, the management of risks to people's safety, sufficient and suitable staffing levels, person centred care and the governance of the service.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Strode Park House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors and two medicines inspectors.

Service and service type
Strode Park House 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. Strode Park House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 27 September 2022 and ended on 6 October 2022. We visited the service on 27, 29 September 2022 and 3 October 2022. We continued to review additional evidence submitted by the registered provider and completed this on 9 November 2022.

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

During the inspection
We spoke with six people who used the service, two people's relatives and one personal assistant about their experience of the care provided. We spoke with nine staff including the registered manager, senior support staff, carers, registered nurses, activities coordinator and occupational therapist. We also spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included ten people's care records including medicine records. We looked at four staff files in relation to recruitment. Records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely
People's medicines were not being managed effectively and people were at risk of harm.
● There was a lack of robust systems in place to ensure that people who displayed anxious or distressed behaviours were not being inappropriately controlled by the use of PRN 'as required' medicines. People's records did not state why they were prescribed these medicines, the maximum daily dose or give guidance on the circumstances under which it should be used and the alternatives to be tried first. When the medicines were used there was no record made of the reason or the outcome of its use to allow analysis. For example, one person was prescribed a medicine to be given only 'as required'. They were being given this medicine routinely twice every day, with no documentation as to why or what other strategies had been used prior to administering the medicine.
● People were not always receiving their medicines as prescribed. The electronic medicines administration records (e-MAR) system was not providing staff with accurate information about medicines stock levels due to technical issues. This had resulted in some people not receiving their medicines due to stock shortages. One incident occurred when an epilepsy rescue medicine was not in stock for a person who it was prescribed for. This was only noted by staff as being out of stock when the person had a seizure. Immediately following the seizure, the person was given a different medicine, which was one of their regular prescribed medicines, which staff told us was to prevent any further seizures. However, there was no guidance to show it had been prescribed to be used for this purpose.
● Staff did not always administer medicines safely. For example, one person was given a double dose of their sleeping medicine as staff had not communicated between them that the person had already had that medicine. Another person was administered an antibiotic that they were allergic to. The person's care plan detailed they were allergic to this medicine, but it had not been picked up by the prescriber or the staff administering the medicine. The provider took immediate action when the error was identified. Whilst there was no harm to the person the risk of harm had not been managed.
● Medicines were not consistently being stored safely. Medicines were stored in cupboards in people's rooms but were not stored securely. One cabinet was found to have the key in the lock. This was dealt with immediately when we alerted staff. Keys to the cupboards were kept in key lock boxes in people's rooms which were protected with combination codes. During our inspection, of the 21 key boxes checked, 18 were found to be set to the open lock combination giving people access to their keys and therefore their medicines. There had been an incident prior to the inspection where a person gained access to their medication and taken more than prescribed. People were at risk of taking their medicines not as prescribed.

● People's thickener powders for their drinks were not stored securely and were easily accessible to people in their room or in open stock cupboards around the home. People were at risk of ingesting the thickener powder and choking. Following a patient safety alert in 2015 at another service, where a care home resident

died after accidentally ingesting thickener powder, best practice guidance was issued to keep the thickener locked away and out of reach.

● Oxygen cylinders were not secured to the wall. CQC guidance states that oxygen should be stored securely to prevent from falling and to reduce the risk of harm to any personnel attending the service in an emergency such as fire officers. Following inspection, the provider secured the oxygen cylinders to a wall to prevent falling.

Learning lessons when things go wrong

● The service recorded and investigated incidents, however learning from incidents was not always shared with staff. For example, when we asked staff about the lessons learnt and action taken following an incident in relation to a person's specific health need, a senior staff member did not know about it. The registered manager told us they had investigated and acted promptly at the time but not shared any lessons learnt with staff following the incident. Therefore, not all staff were not aware of what to do to prevent similar incidents happening again which placed this person at risk of harm.

●Following an incident where a person had accessed and taken too much of their medicine, the provider had not ensured that the storage of medicines was always secure. As reported above we found 18 people's medicines not stored securely at our inspection.

● The provider had not monitored the use of restrictive practices in regard to the use of 'when required' medicines to manage people's behaviours. The provider and registered manager had not analysed incidents where people were administered medicines to manage anxiety and distress in order to reduce the risk of recurrence of their use.

The provider failed to ensure the proper and safe management of medicines and take appropriate action to analyse and mitigate risks following incidents. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People's specific health risks were not always managed effectively. Important information about risks and how to manage them had not always been shared with staff. People who lived with diabetes did not have effective and detailed diabetes management plans in place to support staff to recognise and manage hyper and hypoglycaemia risks. Hyper and hypoglycaemia is where a person blood sugar levels drop too low or go too high, which can be dangerous if not treated quickly. Some staff we spoke to were not sure what signs and symptoms to look for to indicate someone may be unwell with their diabetes. People who were diabetic were at risk of staff not recognising if they displayed symptoms of high or low blood sugar levels or knowing how to respond.

● People who were at higher risk of constipation due to medicines they were prescribed did not always have a support plan in place to guide staff to manage this risk. For example, one person was prescribed a medicine which increased the risk of constipation. The person's care and support plan failed to highlight this or provide guidance to staff on how to support the person or when to seek advice regarding constipation. The service monitored bowel movements for people, however they did not always identify in care plans if people were at increased risk of constipation and may need medicines to help with this.

● Not all people who were at risk of choking had an up to date management plan in place to inform staff how to support them safely. One person had had a recent choking incident, but their care plan had not been updated following this to provide guidance to staff in managing this risk. An incident had occurred where another person had put their continence pad in their mouth. Appropriate action had not been taken to assess the risk of this happening again and to consider the risk of this causing choking. Following the inspection the provider told us they had implemented a risk assessment and sought advice from the speech and language therapist team (SALT) and we will review this at our next inspection.

The provider had failed to assess the health and safety risks to people and to do all that was reasonably practicable to mitigate those risks. This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● Fire safety guidance had not been consistently followed. Although on the day of inspection we were asked to sign the visitor's books, this was not the case with some relatives who visited. The records showed that one relative who visited the home nearly every day was not signing the visitors' book. The registered provider told us they had been nominated as designated care giver under COVID-19 visiting arrangements guidance at that time. However, there would still need to be a record of their presence in the building to ensure the fire service could respond appropriately in an emergency. The registered provider told us they had since taken action to ensure everyone entering the home signs in.

Staffing and recruitment

● People and their relatives told us they felt there was not enough staff to meet people's needs in a timely way. One person told us, "There is never enough carers, they are always short." A relative told us, "The staff is lacking." One person told us that they often had to wait long periods of time for help with managing their continence. Other people acknowledged that although staffing had been impacted by Covid they felt the provider was managing it as best they could. One person told us "great care and consideration had been given to prioritise staff resources most effectively. I gave the example of staff ensuring that people, including myself, were able to get out of bed at the time nearest to that requested even if this was occasionally later than previously". Another person told us, the staffing levels at Strode Park are good.

●Staff told us there was not enough staff to support people. Comments included, "Even with a full rota of staff it is a bit tough", "I'd be lying if I said we have enough staff" and "I think we do have difficulty with staff there are times where bank staff are being used and don't know people and don't know what the extra mile is. Sometimes it's difficult for staff on the floor trying to cover everything when someone has gone off sick."

● During the inspection we heard a call bell ringing continuously for 20 minutes. Following the inspection visits the manager sent us records of call bell response times. This showed number of occasions where call bells were ringing for a long time, three of these occasions were over 50 minutes. The provider provided us with an explanation for these incidents of long wait times. Also, during inspection, a staff member showed us the call bell system and when pressed in someone's room, staff came promptly to answer the bell, unaware it was a false alarm.

● Staff had been recruited safely. Checks were completed to make sure new staff were suitable to work with people. Two references, including one from the most recent employer, and Disclosure and Barring Service (DBS) criminal record checks were obtained. DBS checks help providers make safer recruitment decisions.

● The provider had introduced the Nurse Associate programme in 2020 with two care staff recently qualifying as nurse associates.

● The provider was operating a values-based recruitment programme and had introduced retention bonuses and staff referral reward schemes with a view to attracting and retaining skilled staff.

Systems and processes to safeguard people from the risk of abuse

● Staff had training on how to recognise and report the signs of abuse and they knew what action to take.

● Staff we spoke to knew about safeguarding and what would constitute as abuse. One staff member told us "Any abuse or neglect or a change in someone behaviour, or if I saw something people aren't supposed to be doing".

● People told us they felt safe living at the service.

Preventing and controlling infection

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

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● 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.

● The provider ensured themselves, as far as possible, that visitors were symptoms free.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

● Staff had not always received training to enable them to deliver safe care responsive to people's needs. The registered manager told us it was optional for nurses to take part in specific training that covered areas such as the administration of emergency epilepsy medicines and PEG care. A PEG is a flexible feeding tube that goes through the person stomach. Although these areas are included in the nursing qualification the registered manager was not able to evidence that nursing staff were up to date about best practice in care provision in these areas. It would be beneficial for nursing staff to undertake continuous professional development that includes training in the specific health needs of people using the service.

● Training in catheter care had not been consistently effective in ensuring safe practice. One person's relative told us that they felt the catheter hygiene for their relative was poor and they told us they had a number of urine infections since living at the service. Another person at the service was involved in an incident where their catheter had been inserted incorrectly. Following inspection, the provider provided evidence that other catheter changes had been successful.

● Assessments of staff skills and competence were completed; however, these were not always effective. For example, medicine competency assessments were carried out, but these had not been effective in eliminating medication errors. There had been a number of medicine errors in the service prior to the inspection visit.

We recommend the provider reviews their training programme to ensure it reflects the needs of all people in the service.

Most staff had received training in caring for people with a learning disability. New guidance, issued in July 2022, requires all staff to have undertaken learning disability training in services that support, or may support, people with a learning disability. There were some staff that had not yet completed this training, but the registered manager was aware of this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● People's individual dietary needs and preferences were not always met. The service had recently started to trial an external company to deliver food as they were unable to provide the staff required in the kitchen to prepare and cook meals on site. The registered manager told us that about fifty percent of people did not like the new food. The provider told us that alternatives were always offered, but during the inspection we observed a staff member take the person's lunch away that they had not eaten, and they were not offered an alternative. People and their relatives gave mixed reviews about the food. Some people told us they did not like the food they were offered, and they were not always offered an alternative. One person told us, "I

don't really like the food, I didn't like todays lunch as it was Quorn, I might not get anything for dinner if I don't like it". However other people felt the food was good, for example, one person said, "I enjoy the meals and that I was part of the resident led tasting sessions.

●People told us special desserts were not being offered or provided for people who were diabetic. One person told us they had to go shopping for their own stock of diabetic yoghurts for pudding. We spoke to the registered manager regarding there being no diabetic options and they told us they were in the process of organising this.

● One relative told us that the meals were 'carb heavy' with lots of potatoes and pasta. They explained their relative did not like potatoes, but on a number of occasions the staff tried to give them potatoes and staff told the relative were not aware they didn't like it. Following the inspection, the provider gave evidence that extra meals were provided if necessary.

● Care plans did not consistently reflect all areas of people's needs. For example, one person's support plan advised staff that if their BMI (body mass index) was to fall below a certain threshold then they should consider a referral to the dietician. Records showed this person's BMI had fallen below this number, but staff told us this was part of a planned goal for the person to lose some weight. This was not detailed in their care and support plan and conflicted with the instruction to refer to the dietician.

● People's needs were assessed using recognised tools including skin integrity and nutritional needs. However, some information in care plans was conflicting. For example, one person's care plan stated they no longer smoked and that they used nicotine patches. However, their daily notes and risk assessments detailed the person was smoking. People were at risk of not being supported in line with their care plan and which could lead to implications for their health.

The provider failed to ensure care was designed to meet people's needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's rooms were personalised and well maintained, and there was some signage to direct people who could become disorientated to different parts of the service.

● People spent time in the garden which was easily accessible for wheelchair users and it was well maintained.

● People were provided with the equipment they needed to meet their needs and the layout of the premises supported those with a physical disability.

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

● People had regular access to specialist and routine healthcare. People's care plans detailed when they had been for a routine healthcare appointment, such as dentist, chiropodist or opticians.

● The service had its own occupational neurotherapies team on site to support people with recovery. People who required neurorehabilitation were supported by the team to create a routine and work on achieving personal goals such as getting out of bed independently.

● The registered manager worked closely with the GP surgery. A GP carried out visited once a week to discuss any concerns people or staff had. If staff needed to contact GP in between visits, they were able to call them and get some advice. One person told us, "The doctor comes every Monday. if I need to see them but if it's before, I can speak to someone".

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Where people were unable to consent to care or treatment mental capacity assessments had been carried out. We saw a decision had been made on behalf of a person to use a baby monitor for their safety during periods of crisis. The person's care plan said they had fluctuating capacity, but no capacity assessment had been completed to see if they could make this decision. During the inspection we saw the baby monitor in use at times when the person was not unwell or in crisis and the baby monitor was not required. Following inspection further information and consent has been obtained from the person and detailed within the care plan.
- People had DoLs in place where they were appropriate and necessary.
- People were asked for their consent before care was provided. For example, we observed staff knocking on people's doors before they entered their room.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always respected and promoted. One person told us staff were not always helpful and empathetic with their condition and did not receive dignified care. They told us staff did not always believe them when they said they needed support with personal care and they had to evidence to the staff that they needed the support before it was provided .
- Another person told us they would not be able to go out if they only relied upon the support of staff at the service. They said they felt institutionalised. The person told us they felt the staff were caring, there just wasn't enough of them to support with going out, even just into the gardens.
- We saw staff speaking with people in a kind and respectful way. Some people gave positive feedback about the service . For example, one person felt the staff team were "approachable, willing to listen and extremely caring". Another person felt that staff always worked hard to make sure they are comfortable and safe.
- Staff told us they supported people to be as independent as possible. One staff member told us, "I try and treat everyone as if they didn't have disabilities and if they cannot use hands or talk, I ask if they want me to do things to give them a chance to say I don't want my hair brushed now."
- We observed staff respecting people's privacy. For example, staff would knock on people's door before they entered their room.
- The service employed a team of physiotherapy and occupational therapy staff to help people to increase their independence.

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

- Most people had been involved in developing their care plan where they were able.
- The service supported people to express their views regarding their care and support. A people's representative and an advocate were available for people to speak with and share their positive and negative feedback. Feedback from people would then be discussed with senior leaders at the service.
- People were supported to maintain links with people that were important to them. We observed people being part of visits with family members.
- Some people told us they felt staff listened to their views, one person told us, "The team are approachable".

Requires Improvement

Is the service responsive?

Our findings

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

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

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

● People were not consistently supported to take part in meaningful activities. One person told us, "It feels very institutionalised." Another person told us, "Going out can be tricky, the carers don't have enough time." A person's relative told us, "They have no stimulation, they lay in bed and watch TV all day." However, some people fed back that they were happy with the activities provided. One person said they had been supported to visit Wildwood nature reserve. Another person said residents do have the opportunity if they wish to take part.
●Records show that one person who was cared for in bed was not offered appropriate and meaningful activities. It was recorded that they had watched tv seven times and had one chat with a staff member during September 2022. There was not an effective care plan in place for meeting this person's social and emotional needs.
● The service had an activities coordinator and they told us they were not always able to provide the level of activities and support people needed, however they also highlighted where they have worked hard to supported people with the resources they have. Other staff told us, "I might get around to everybody once every 6-8 weeks.", "Activities could definitely be better." and "Personally, I feel like there isn't enough.
● Care plans did not always reflect of people's preferences or their routines to guide staff in delivering personalised care. One person's care plan had not been fully completed and did not detail what the person's preferred daily routine was, their likes and dislikes, strengths or what was important to them.
● Some people's care plans contained limited information about their life history that would improve staff's knowledge and understanding and to better inform how to support that person. One person's care plan did not detail any information regarding their life prior to living at Strode Park. Information about people's background and preferences would help staff to plan for meeting their social and emotional needs. Following the inspection, the provider provided evidence that some care and support plans contained more information about people.
● Staff told us that they tried to support everyone when they ask to be supported, but that there were not always enough staff to allow this. One staff member told us, "We aim to give everyone care before lunch time but sometimes we don't get time to breathe." Some people felt they were not always able to get out of bed when they wanted due to their being not enough staff. One person told us, "I tend to fit around them, it's too much hassle to get up as two staff need to support me." The provider told us that workforce pressures in social care had sometimes impacted on people receiving their care at their preferred time.

The provider failed to ensure care was designed to meet people's needs and preferences including their

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

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

● People's care and support plans detailed how people preferred to communicate. For example, one person's care plan detailed information given needed to be short and simple and guided staff to use reflective listening to ensure understanding on both sides.
● Staff were able to tell us how they supported people who used different communication methods. For example, one staff member told us, "[person's] communication was limited when they came here but we used picture cards to help and since then their communication has improved".
● Another staff member told us, "We have one person who will blink and move their head for yes and no if you ask them a question."

Improving care quality in response to complaints or concerns
● People and their relatives told us they would know how to raise a complaint or a concern. One person told us, "I can speak to the manager if I'm not happy."
● The registered manager told us if a complaint was raised it would be looked into and dealt with in line with their policy.
● One person told us, "I have always found the management to be responsive to residents/ family needs". Another person told us, "If there is an issue; changes are made if possible".

End of life care and support
● People received the support they needed at the end of their life. Anticipatory care plans were in place so medicine prescriptions were ready for when people needed them.
● Staff were able to tell us how they supported people who received end of life care. For example, one staff member told us they supported someone by comforting them and following what the nurses said they needed. Staff also told us they had completed training around end of life care.
● People were involved in their end of life care planning. If people expressed they did not wish to talk about it yet, then this was respected and recorded in their care and support plan.

Inadequate

Is the service well-led?

Our findings

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

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

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

● Governance processes were not consistently effective to keep people safe and provide good quality care and support at all times. The provider had not ensured that a robust system to analyse incidents and accidents was in place. The registered manager told us since moving to an electronic recording system there was less reporting of incidents. The registered manager identified there was more reporting from staff in comparison to after the new systems was implemented. The registered manager told us they are in the process of implementing a new way of recording incidents that they hope will be easier for staff.

● The provider had not always ensured that lessons learnt from incidents were shared with all staff to reduce the risk of recurrence.

● The provider had failed to act appropriately on concerns they had identified regarding the medication system. The registered manager told us they had been using this system for about one year and identified repeated concerns regarding the volume of stock in the service, but no action had been taken until recently.

● The provider had failed to recognise and mitigate the shortfalls regarding the management of people's specific health risks. People's care plans and risk assessments were not always up to date or reflected people's current needs. Guidance was not always clear for staff about how to manage people's specific health risks, such as diabetes.

● People's care records contained conflicting information. For example, one person's daily notes detailed that they had not received their fluid and nutrition as per their regime. However, when we spoke to staff it had been recorded on another system and this made it difficult to have an overview when people received care that was in line with their support plan.one staff member told us, "The electronic system is reliant on a strong WIFI connection, if it goes down we can't log our notes."

●The service used an electronic system to record people's care and support. The electronic system allowed staff to view people's care plans and personalised tasks were able to be added to include all the aspects of people's care, this included thing such as PEG care which was specific to that person. Staff told us, "Its quicker and easier to look up information." However, staff also felt the issues with the WIFI signal could sometimes interfere with data being saved.

● The service had not consistently ensured that enough staffing resources were available to support people with activities. Staff, people and their relatives felt there could be more resources and support for people to take part in activities.

The provider had failed to have robust oversight of the service. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider had failed to consistently ensure they promoted a culture that was inclusive and empowering. The registered manager did not have systems in place to ensure all people were being supported by staff to regularly take part in activities. Although some people and their relatives also told us there was not enough activities, other people felt there were enough activities.

● The provider had failed to ensure people consistently received good care from staff. The registered manager did not have a robust system to ensure people received consistent, good quality care. People and their relatives told us of occasions where they were not always supported how and when they wanted. For example, one person told us staff were not supportive when they asked for support with personal care.

● The provider and registered manager failed to create a culture of learning, where staff were able to challenge processes and practices in place. For example, 'when required' restrictive medicines were being administered frequently and without guidelines of how and when to use them and staff had not challenged this.

● The model of the service did not reflect the Right support, Right care, Right culture guidance. The size and model of the service did not reflect the guidance which is underpinned by the NICE guidance. This guidance recommends that services supporting people with a learning disability, autistic people, or people with a mental health disorder should not accommodate large numbers of people. This is to ensure people receive the person-centred support they need. The service was supporting people with a learning disability at the time of the inspection.

The provider failed to ensure care was designed to meet people's needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager worked with other services within the Strode Park Foundation. One person had been moved from another Strode Park service due to their temporary nursing support needs. However, there was no clear plan for the person to return home or what action would be needed if they were unable to return back to their home, as this service was not suited to their other needs.

● The provider appointed a resident of the service to advocate for other people. People could raise issues with the advocate if they did not feel they could go to a member of staff. The advocate would then inform management of any concerns highlighted in order for them to be addressed. Issues that have been highlighted through this channel are the food and lack of activities. The registered manager told us they are trying to encourage people with the new external food menu and will be looking at activities.

● The provider gathered feedback from relatives when they reviewed person's care. Relatives confirmed they had been asked for their feedback in the past.

● Staff we spoke to said that they felt supported by the management at the service. Staff were also complimentary about the registered manager saying, "they are nice and approachable."

● One person told us, "I assisted a family member to set up a 'Family Forum' a platform for people and their families to be heard which had the total backing of the management and was active for 2 years until Covid".

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 understood their legal duty regarding duty of candour. Where incidents had been

reported, people's relatives were informed.
● The duty of candour requires providers to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.