Care Quality Commission

Centurion Health Care Limited

69 Chartridge Lane

Inspection report

69 Chartridge Lane
Chesham
Buckinghamshire
HP5 2RG

Tel: 01494810117
Website: www.centurioncare.co.uk

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Ratings

Overall rating for this service	

Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Summary of findings

Overall summary

About the service
69 Chartridge Lane is a residential care home providing regulated activities to up to six people. The service provides support to people with a learning disability, autistic people and people with a mental health condition. At the time of our inspection there were six people using the service.

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.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

Right support
The service did not effectively support people in relation to recognised models of care for people with a learning disability, autism and behaviours that challenge, such as positive behaviour support approaches (PBS) and support to engage people in relation to their communication needs. As a result, whilst we saw features of positive support, including choice, participation, and inclusion, these were not consistent.

Right care
People were not protected from abuse. The provider had not always recognised or identified that certain incidents needed reporting and investigating to see if further risks could be reduced.

Staff did not always have the relevant skills or experience to ensure people received the appropriate care. Training had not been completed in line with people's assessed needs.

There was no evidence of how people, or the people that were important to them, were involved with their care.

Right culture
People were not always supported by a management team and staff who fully understood the holistic needs of supporting people with learning disability and autism. The culture of the home restricted people as the ethos, values and attitudes of the management team and staff were not empowering.

The service had not taken the necessary action to address concerns such as risk of fire since the previous inspection.

Staff and managers had not received training in managing behaviours that challenge and how to support and reduce anxieties and triggers for behaviours. Staff and managers had not explored the importance of communication in both engaging people in making decisions and in helping people to manage distress and anxiety which could lead to incidents of harm to themselves and others.

The failure of the provider to fully meet the underpinning principles of Right support, right care, right culture, meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

People's medicines were safely stored and generally well recorded. However, we were not assured that all staff had received the training and had their competency assessed before administering medicines to people.

Staff training records showed that the provider's required mandatory training had not always been recorded as having taken place. Staff told us they had not received training in people's specific needs, such as mental health, communication, autism and positive behavioural support.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

The provider had enlisted the services of a Care Consultancy who had identified these issues before this inspection and had developed an action plan. However, at the time of the inspection not all necessary actions identified had been completed so we could not be fully assured of the effectiveness of these actions.

The provider and Care Consultancy were in regular discussions with relevant external bodies to provide an overview of improvements to ensure people's safety.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 4 April 2020.

The overall rating for the service has now changed to inadequate based on the findings of this inspection. This service was rated as requires improvement at previous two consecutive inspections. 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 the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received in relation to the provider's management of risk. A decision was made for us to inspect and examine those risks.

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 found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. 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 six 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.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will 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 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**

Care Quality Commission

69 Chartridge Lane

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 completed by two inspectors and a medicines inspector. An Expert by Experience made telephone calls to people's relatives to gain their feedback. 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
69 Chartridge Lane is a 'care home' without nursing care. 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The service was being managed by an interim manager and oversight of management from a Care Consultancy.

Notice of inspection

This inspection was unannounced. Inspection activity started on 4 April 2022 and ended on 27 April 2022. We visited the service on 4 and 12 April 2022. We continued to gather further information remotely from the provider until 27 April 2022.

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 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with three people living at the service and also spent time observing people to help us understand the experience of people who could not talk to us. On the first day of the inspection, we spoke with two members of staff and a care consultant who was overseeing the service on the day. On the second day of the inspection, we spoke with the interim manager. We also spoke by phone to the nominated individual for the service. A nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed care records of three people to help us assess and understand how their care needs were being met, and a number of medication records. We also reviewed records relating to the running of the service. We looked at two staff files in relation to recruitment and staff supervision. We also reviewed agency staff profiles. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

After the inspection, we spoke with five relatives about their experience of the care provided. We sought online feedback from seven staff members.

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

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last inspection, we recommended that the provider found out more about training for staff, based on current best practice, in relation to risk management within the service.

At this inspection we reviewed whether the recommendations had been followed up. We continued to find concerns in relation to night-time staffing levels and fire risk.

● The provider had arranged a fire risk assessment which took place in March 2022 and this stated, 'Following analysis of the Personal Evacuation Emergency Procedures (PEEPs) it is confirmed that the Fire Safety arrangement at this building do not currently comply with statutory obligations: Specifically there is not suitable provision of staff overnight to provide effective evacuation: Specifically given that one resident requires two persons to assist them to evacuate. Consequently, an enhancement to night staff must be undertaken immediately it is recommended that two members of staff undertaking night duty. This could be based on a member of staff doing a sleep-in duty and the current provision of a waking staff member.'
● On the first day of the inspection we were informed that the staffing level overnight was one member of staff. We saw on the rotas that this was sometimes a member of agency staff. There was no evidence that agency staff had received any induction or training in relation to fire evacuation.
● Following the first day of the inspection, the provider took action to put an additional member of staff in overnight. On the second day of the inspection, we were informed by the manager that a practice evacuation had taken place during the day and all were safely evacuated, and staffing had reduced again to one overnight.
● We are not assured that the actions taken by the provider were sufficient to ensure that in the event of an emergency during the night when all people were asleep and only one member of staff, that they would have the assistance to safely evacuate the premises in a timely manner.
● People did not always have Personal Evacuation Emergency Procedures (PEEPs) which provided information if there was an emergency such as fire and the building needed to be evacuated. We found people's PEEPs were not always in place, up to date and accurate. For example, one person had no PEEP in place despite being in the service for over a month. People's needs were not clearly listed on the PEEPs such as sensory impairment (sight and hearing) and how this disability may impact upon their safe evacuation. Autistic people can need time to process information and there was limited information about how the person may react to an urgent request.
● People's care records were not used or analysed to get them the support they needed. We saw that one person had lost significant weight in one month. The weight loss had been recorded, but no action had taken place to refer the person for investigation by a relevant health professional. This was despite a multi-

disciplinary meeting with an action on the provider to make a referral to the dietitian by 5 April 2022. We asked the manager about this on the second day of our visit, 12 April, who confirmed there had been no referral to a dietitian but said they would mention it to the dietitian who was visiting another person in the service the day after our inspection.
● Full information about risks to people's safety was not always passed on to staff who needed it. For example, a person's records stated they need 'lots of fluids' due to a health condition and staff were to 'monitor [person's] intake. There was no risk assessment in place in association with this and no target of daily fluid amount to aim for and limited recording. Only three members of staff had received training in relation to nutrition and hydration. The lack of record keeping, and staff training put the person at risk of dehydration which could affect their health condition.
● A person's records also stated they were at high risk of choking. There was no risk assessment in association with this risk. We also noted that not all staff had completed dysphagia training. The lack of record keeping, and staff training put the person at risk of choking.
● Not all relevant referrals had been made when they should, to share responsibility for care of service users in a timely manner. For example, no referral had been made to a health professional in respect of choking risks to a person. The manager said they would make the referral immediately. However, this lack of referral meant the person was not kept safe through the formal sharing of information in relation to potential risks identified.

This demonstrates a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always kept safe from avoidable harm because safeguarding concerns had not always been referred to the relevant bodies as required by law. We saw incidents had taken place with no investigation or actions to keep people safe from potential further incidents.

This demonstrates a breach of Regulation 13 (Safeguarding from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had training on how to recognise and report abuse to management. A member of staff said, "Safeguarding is protecting residents from abuse or neglect which can be financial, physical. Recently, I witnessed something which I believed was neglect and reported it to the manager".

Staffing and recruitment
● Staffing levels were not sufficient to keep people safe from harm. We noted two incidents that had taken place during a night shift when an agency worker was on duty. People had not received the support they required as a result of insufficient staffing levels.
● Family members expressed concern about the lack of management of the service, the loss of senior staff and the use of agency staff. This led them to have concerns about their relative's care. Comments included, "A couple of times I have phoned, and the carer has said 'I'm on my own'. On [date] I had to take them to a [medical appointment] as there were no staff to take them" and "A couple of weeks ago, [person] said they were upset as there were not as many staff as there used to be, it was a Saturday".
● Staff gave mixed views about staffing levels. One staff member commented, "Not at the moment (believe there is not enough staff), we are actually doing long hours, but I do know we are recruiting and there are some old staff coming back. So, this would help." Whilst another staff member told us, "As much as I know, it is okay. We don't have more than one agency a day to work here."
● Safe recruitment was not always evidenced. We noted two members of staff only had one reference on

their files. We raised this with the manager who said they would follow this up. Staff spoke about their recruitment experience. For example, a staff member commented, "I phoned (the service) and they sent me an application, they arranged an interview, I gave them my NVQ certifications level 2 & 3 and end of life training certificate. I was not able to start work until my DBS was cleared."

This demonstrates a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● We asked on the first day of the inspection to see evidence that staff had received training and had medicines competency assessments completed. These could not be found. We asked again on the second day and they could not be found. We asked for evidence of these to be provided. We were eventually sent a training matrix 15 days after the request, which had dates when medicines training and competencies had taken place but saw no evidence of these as requested.
● The provider usually carried out medicines' audits, however we found on inspection this had not been done for the last three months.
● An action plan completed prior to the inspection stated the 'service to commence competency assessment for staff administering medication'. We therefore were not assured staff had received training and competency assessment to ensure safe administration of medicines.

This demonstrates a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely.
● The provider did not have controlled drugs (CD's) in the premises on the day of our inspection. However, appropriate storage facilities and CD protocols were in place.
● Protocols were in place for medicines prescribed on when required basis to enable staff give these medicines consistently.
● Care plans included medicines risk assessment information.

Learning lessons when things go wrong
● The provider had not managed incidents affecting people's safety well. Incidents had not been reported appropriately and the provider had not investigated incidents and shared lessons learned.
● The service's accident and incident records showed incidents were linked to behaviours that were considered challenging to staff or others. There was limited evaluation of these incidents to inform the provider and care staff how incidents could be minimised or managed more effectively in the future.
● Even though people demonstrated behaviours that were challenging to staff (including agency staff), staff had not received training in positive behavioural approaches.
● The provider had enlisted the services of a Care Consultancy who had identified these issues before this inspection and had developed an action plan. However, at the time of the inspection not all necessary actions identified had been completed so we could not be fully assured of the effectiveness of these actions.

The above demonstrates a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● Not all staff had completed food hygiene training.

- We requested, but did not receive, the service's infection prevention and control policy to ensure it was up to date.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
The service was following up to date government guidance in respect of visits to people in the service.

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

- People were not supported by staff who had training in relation to people's specific needs. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, including communication, positive behaviour support (PBS), autism awareness, dignity, equality and diversity and person-centred care.
- We spoke with two staff about attending training in relation to learning disabilities. One staff member stated they had not received the relevant training and another staff stated they had obtained relevant training, but this is something they had arranged outside of their employment.
- We were concerned the service did not promote anti-discrimination values in relation to people with a learning disability, which is a protected characteristic in law.
- The staff induction and training processes (including for agency staff) did not always promote safety, ensure staff had the right skills, competence or experience to support people's assessed needs. The provider's training matrix evidenced many areas where training had either not been delivered or had been provided many years ago. Much of this training was significant to ensure people's needs were fully understood by staff.
- Where agency staff were used, there was no evidence on their profiles that they had received the necessary training, such as epilepsy and experience in working with autistic people or people with a learning disability. We saw on the rota that at times one agency worker worked alone overnight supporting people.
- The provider's training matrix showed staff had not completed mandatory refresher training in line with timescales. For example, PBS training was listed as being a yearly requirement. We saw that one member of staff attended this in 2014 and only two members of staff in 2020.
- The provider had enlisted the services of a Care Consultancy who had identified lack of training in certain areas before the inspection and had developed an action plan. However, at the time of the inspection not all necessary actions identified had been completed so we could not be fully assured of the effectiveness of these actions.

The above demonstrates a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff felt adequately supported and told us about their supervision experience. A staff member commented, "I had two supervisions (recently). They helped me to know my level of understanding things such as residents needs and to identify if I need more training. I found them helpful and also to correct me if I have done something wrong." Another staff member told us supervisions were carried out every three

months until the former registered manager's recent departure.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

- People did not have as much freedom, choice and control over their lives as possible. We noted one incident had been recorded about a person becoming emotionally distressed due to a member of staff informing them they could not undertake a particular activity. A member of staff told us this was because the person would be tired the following day. There had been no consideration of how to enable this activity to take place by undertaking some adjustments the following day. There was no analysis of this incident with any actions taken to change or adjust practice to enable the person's choice.
- There was not a comprehensive assessment of each person's physical and mental health undertaken by the provider either on admission or soon after. We did see some documentation on people's records that had been submitted by the local authority before care commenced.
- One person did not have evidence of information being transferred into a care plan or risk assessments following their move to the service. The person was at risk of choking. A relative said, "I don't even know if there is a [care plan]. [Care staff] were going to do one, then they left. I hope it's done soon". We saw completing this support plan was on the action plan but the target date did not prioritise the urgency of this. The absence of an up to date support plan and assessment and management of risks put the person at risk of unsafe care.
- People's support plans did not always contain evidence-based best practice and up to date guidance. For example, the service had not assessed a person despite stating they were at risk of choking. There was no guidance for staff about how to minimise the risks to the person.
- There were no oral health care plans in line with evidence-based best practice and up to date guidance.
- People were not always referred to health care professionals in a timely manner to support their wellbeing and help them to live healthy lives.
- There was limited information relating to people's future goals and long-term aspirations in people's support plans.

This demonstrates a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

- Care staff understood the MCA as it related to their job role and told us how they would obtain people's

consent when carrying out care and support tasks.
● On the first day of the inspection, we asked for evidence that appropriate DoLs applications had been submitted and whether any authorisations had been granted to ensure people's freedom was being restricted lawfully.
● On the second day of the inspection, we saw that authorisations had been made for four people and one was waiting for the local authority to respond. We were sent a copy of a matrix to track people's authorisations. CQC has not yet had a notification as required in relation to these authorisations.

Supporting people to eat and drink enough to maintain a balanced diet
● We reported in the Safe section of this report that a person was at risk of dehydration as fluid levels were not recorded.
● Other people's records contained information to support them with choice and a balanced diet. One person's support plan had information for staff to help guide the person's hand around the plate, as this would help the person know what food was on the plate and where the food was. This was observed during our visit.
● Staff were instructed how to support the person during meal times, for example to use open ended questions to ensure any response was meaningful and record what food was offered, how much was eaten, and if it was refused what was the alternative, and what he had drank (although amount was not recorded).
● Staff were aware of a person's food preferences. When discussing favourite meals a staff member commented, "[Person's favourite meal, burger chips and garlic bread, like anything that can be picked up by hand."
● People with complex needs received support to eat and drink in a way that met their personal preferences as far as possible. This was supported by the person's support plans which stated the person liked to eat food they could easily pick up with their hands.

Adapting service, design, decoration to meet people's needs
● People's care and support was provided in a safe, clean, homely and well-maintained environment. Staff were aware that due to one person's visual impairment it was important to maintain routine and keep hazards out of the way.
● People's rooms had been decorated in line with their individual preferences. Staff told us people were involved in personalising their rooms. One person showed us the cuddly toys in their room which were clearly important to them.

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 were not always feel well-supported to express their views and make decisions.

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

- We sought feedback from relatives of people in the service who knew people well. We had mixed views. One relative said, "Regular staff are lovely". However, there were concerns expressed about the turnover of staff and high use of agency staff. Comments included, "We have no idea who the staff are anymore. Not sure who's left and who is still there. We have not been told" and "Agency carer was not talking to [person] at all. Last night I heard the regular carer talking to her constantly, and she was giggling and obviously enjoying it".
- Staff interactions with people was mostly kind and considerate. People were comfortable with staff and actively engaged in jovial conversations with them.
- People's individual interests, routines and habits were known by the staff who supported them. We observed people spending time doing individual activities they seemed interested in either the home or out in the community.
- Staff knew what range of options each person might want to choose. For example, they told us a person loved to go out for walks. We observed the person was taken out by staff to go for a leisurely walk.

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

- There was limited documentary evidence of how people were involved in decisions, including people who knew them well, to help support decision making. Relatives we contacted said they did not always feel communicated with in respect of important decisions such as health and updates.
- Staff told us people were able to express themselves and they would support them by giving choice. When referring to a person, a staff member commented, "[Name of person] uses short sentences, you have to be careful and ask him more than once as he would say 'yes' to everything, and you need to make sure what he is saying yes to, is what he really wants."
- Care records documented how people liked to express themselves and how staff should support to do this. We observed people confidently expressing their views during our visit.
- Staff supported people to maintain links with those that are important to them.

Respecting and promoting people's privacy, dignity and independence

- Some people in the service were in paid or voluntary work and the manager said now the restrictions around Covid had reduced they would try and increase this. However, care plans did not contain any information about aspirations and how the outcome of these would be measured.
- Staff spoke confidently about respecting people and promoting people's independence and dignity. A staff member commented, "It (care) always has to be about him (person who used the service). What he

wants to do, most of the time he will direct you. Another staff member said they would allow people to do tasks they were able to do for the themselves, such as putting items of clothing on when getting dressed.
● People were able to stay in the privacy of their own rooms, as and when they wanted and actively participate in daily schedules, such cleaning their rooms and doing their own laundry. This was observed during our visit.

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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● The provider was not ensuring people were supported through recognised models of care and treatment for people with a learning disability or autistic people. Support was not focused on people's quality of life outcomes and people's outcomes were not regularly monitored and adapted as a person went through their life. We saw no person-centred planning tools and approaches to discuss and plan with people how to reach their goals and aspirations.
● Support plans were not always reviewed to ensure they were up to date and current by gaining information from those that knew the person well. We asked relatives for feedback about how the service communicated with them and included them in relevant conversations to contribute to the person's quality of care. Relatives told us they felt the service had not kept them updated about their family member and were not involved in care reviews. Comments included, "We are not informed of, or invited to care reviews. We want to ensure [person's] health and wellbeing and feel we should be" and "I have never been asked to share anything. I am not invited to annual reviews" and "With a large turnover of staff they are not aware I need to be updated about concerns and developments".

This demonstrates a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Peoples' preferences and interests were documented in people's care records. For example, one person's care plan showed their faith was important to them and they attended church. The service supported the person to attend church virtually during the pandemic. This showed people received care and support responsive to their needs.
● A person spoke positively about the daily activities they were involved in, such as going to college every Tuesday and Friday. What they had shared confirmed what staff had told us.
● When discussing how a person received care and support in a person-centred way, a staff member commented, "I follow the care plan to know what [name of person] likes and what they don't like."
● People were supported to maintain everyday living skills and we observed this during the inspection.

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 (AIS). AIS 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.

● Communication training listed as mandatory had not been delivered to all staff. The training matrix showed two out of 10 staff had attended this.
● Peoples' communications were clearly recorded. A person's care record documented how the person communicated and what staff needed to do to meet their communication needs. For example, we noted staff were told the person could make requests and was able to express themselves but in order for them to understand staff, verbal instructions should be given in a clear and concise manner.

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
● People's support plans did not contain information about goals and aspirations in relation to activities that may be socially relevant to them. Although people were supported to participate in some social and leisure interests on a regular basis, these had not been reviewed to see if the person wanted to try anything new or different.
● Staff supported people to maintain links with people who were important to them. A staff member when talking about a person they cared for commented, "We do phone calls every week with [Person's family]. [They] come and get him and he does [activity] with his family."

Improving care quality in response to complaints or concerns
● We asked for a copy of the complaints policy and procedures from the provider but did not receive these.
● Relatives said concerns or complaints were not always dealt with effectively. One relative said, "We never know who to escalate issues to, and still don't know".
● Complaints were not always responded to appropriately. One person said she had been phoned and told how the issue would be resolved but got nothing in writing to explain how the issue would be avoided in the future.

This demonstrates a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● The service was not providing end of life care.
● Not all people in the service had records that showed that they, and their relatives where applicable, had been asked for their wishes for end of life care. A relative said, "Previous manager sent me the form by email two or three years ago. I could not open it and asked for a paper copy. It was not sent and not pursued, so no I have not completed this".

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 requires improvement. 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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Following the last inspection the provider sent us an action plan. The plan stated they would take actions in relation to accidents and incidents, fire safety, staffing levels and meeting people's health needs. At this inspection, we found none of these actions had been completed and continually monitored.
● The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others.
● There was no registered manager in post at the time of the inspection. The service was being managed by an interim manager and a Care Consultancy who were overseeing all the provider's locations to ensure improvement.
● Staff told us they were not involved in any local and national quality improvement activities relating to people with learning disabilities or autistic people.
● The provider had not provided staff with the relevant quality training to meet the needs of all individuals using the service.
● The provider had not demonstrated compliance with regulatory and legislative requirements. For example, not all statutory notifications had been submitted to the relevant bodies following incidents involving people in the service.

This demonstrates a further breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not have a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible. We asked staff if they knew what the vision was

for the service and they said they were not sure.
● The lack of governance in the service meant staff were not always supported to make necessary improvements in relation to managing incidents. The provider had not ensured that all behaviours and actions of staff were appropriate in relation to when people experienced emotional distress.
● The provider did not have a culture that valued reflection, learning and improvement. Communication with those that were important to people in the service was reported as poor. Comments from relatives included, "Communication is non-existent. We didn't know (name of previous manager) had gone until zoom meeting" and "Know it's (named present manager), that's all. Had no contact and have not been officially informed by the home. Found out from zoom meeting few weeks ago, we did get minutes and have another one next week".
● This meant the service was at risk of creating a 'closed culture'. This is a poor culture that can lead to harm, including human rights breaches such as abuse. The absence of support to evaluate and understand people's behaviours and to facilitate participation meant people were not being fully supported in accordance with the Regulations of the Health and Social Act 2018 (Regulated Activities) and Right support, right care, right culture, which is statutory guidance for service supporting people with learning disabilities and autism issued by CQC. We expect providers of learning disabilities services to have regard to this, in order to maximise choice, control and independence of people using their services. Although we saw no evidence of human rights breaches or abuse during our inspection, there was no evidence of actions by the provider to reduce any potential risk of these occurring.

This demonstrates a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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
● We had not been notified events in the home where a person was at risk of harm or neglect.
● When incidents had occurred there were no reviews of these, we were therefore unable to see if these could have been avoided. We therefore could not be assured the duty of candour was understood and followed.

This demonstrates a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2008

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had neither sought feedback from people and those important to them nor used the feedback to develop the service. A relative said, "We have not had a questionnaire for a very long time".
● Staff told us they had not been asked for their views about developing or improving the service.
● Staff told us they attended regular team meetings and how it helped them. Comments included, "Team meetings are held monthly and sometimes, they were helpful because I was quite new here and some things were about new residents and to find out how we were doing and what support we need" and "We were having them monthly. Now with recent changes (in management), I have asked for a staff meeting so we can meet the new management team."

Working in partnership with others
● There was some evidence that more health professionals were involved with people's care.
● The provider was working with the local authority to ensure improvements were involved in provider engagement groups organised by the local authority which aimed to help improve care services in the local

area.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not operated an effective system for identifying, receiving, recording, handling and responding to complaints.

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 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not always appropriate, met their needs and reflected their preferences.

The enforcement action we took:

To be discussed at MRR

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not always provided in a safe way.

The enforcement action we took:

To be discussed at MRR

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 People had not always been protected from abuse and improper treatment as systems had not been established and operated effectively to prevent abuse.

The enforcement action we took:

To be discussed at MRR

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure compliance with the regulations.

The enforcement action we took:

To be discussed at MRR

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff.

The enforcement action we took:

To be discussed at MRR