Caretech Community Services (No.2) Limited

Church Lane

Inspection report

21 Church Lane
Maidstone
Kent
ME14 4EF

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Church Lane is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Church Lane provides accommodation and personal care for up to twenty adults who have learning difficulties and may also have physical disabilities. The upstairs of the service is called Inglewood, and this provides accommodation and personal care for 10 people who have learning disabilities. The ground floor of the service is referred to as Church Lane. The ground floor provides accommodation and support for 10 people who have learning and physical disabilities. Some people had sensory impairments, epilepsy, limited mobility and difficulties communicating.

The provider has registered the whole service with the Care Quality Commission (CQC) under the name Church Lane. The service has one registered manager and overseen by the same senior management team. The provider employs two deputy manager one who works upstairs at the service and one who works downstairs.

The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. There was a risk that the size of the service had a negative impact on people.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, independence and inclusion. The outcomes for people at Church Lane did not reflect the principles and values of Registering the Right 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 interest. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them. People with learning disabilities and Autism living at Church Lane were not supported to live as ordinary a life as any citizen.

People's experience of using this service

The management and staff had not supported an empowering, inclusive culture.

People were not treated with dignity and respect. The language and actions of some staff was disrespectful and at times abusive. The local authority safe guarding team were investigating, and the investigations have not yet been concluded. People were not being supported to be as independent as they could be with their daily activities.

People were not always safeguarded from abuse and improper treatment. The registered persons failed to

consistently ensure people were protected from avoidable and intentional harm. Some incidents had not been reported to local authority safeguarding team when they should have been. Individual risks to people had not been fully identified and mitigated. Some environmental safety checks had not been undertaken at the required intervals.

There was lack of choice and people were controlled by staff. People were told what they could do and when they could do it. The kitchen door was locked so people could not freely help themselves to drinks and snacks. People said if they wanted drinks or snacks outside meal and drink times they had to ask permissions from the staff. People were told when to get up and when to go to bed. People were given drinks at certain times of the day, not when they wanted them. People were not supported to choose what they wanted to eat and were not able to choose the activities they wanted to do. These decisions were made by staff.

People's health needs, such as constipation and epilepsy, were not always being met effectively. When people's fluid intake was monitored this was not accurately recorded to make sure they were drinking enough. People did not always receive personalised care. Some people's communication needs were not met in a personalised way.

Since living at the service some people had become de-skilled. One person told they used to cook but since coming to the service they were not allowed to do this.

Medicines were not managed as safely as they should be. Medicines had gone missing. Some people were prescribed medicines 'as and when' for behaviours and medical conditions. Some people were receiving these 'as and when' medicines for behaviours regularly. There was no guidance for staff for when these medicines should be given. There was a risk that medicines were given inconsistently.

Some of the staff working with people did not have suitable skills, understanding and values to work with people. These concerns had been identified at staff meetings, but no action was taken by the registered persons. Staff continued to work with people in a controlling, disrespectful and restrictive way.

On Inglewood there was conflict and tensions within the staff group. This had been reported to the registered manager, but no action had been taken. Staff were not regularly supervised and monitored, therefore there was no resolution and no improvements made.

People told us that they had made complaints about the way they were being treated but their concerns had not been taken seriously and no action had been taken. People were not listened to.

Action was not taken to learn lessons and improve the service people received when things went wrong.

Staff including the registered manager had not always received training to help them understand and meet people's care needs. This included training in areas the provider considered mandatory such as infection control, emergency first aid, manual handling and safeguarding people, as well as areas specific to individuals such as the administration of special medicines that people required when they were experiencing seizures and conflict management.

People were not involved in planning their care and support in the way they would have preferred. Consent to care and treatment was not always sought in line with legislation.

Although people received support to go out and about and to undertake activities at the service this was not

consistently provided in the way the people preferred. One person should be going out in a car regularly. This was not happening; from 22 June 2019 they had only been out once prior to our inspection. Staff decided what activities people would do. We found that people had been cajoled into doing activities they had not chosen and had no interest in.

The governance arrangements including the checks and audits had not picked up the range of issues found at the inspection. The culture of staff being in control had not been identified and addressed, so it continued.

There was a lack of oversight and scrutiny by the registered persons. This had led to unsafe risks and care for the people living at Church Lane. Systems for checking and improving the quality of care and support people received did not identify concerns and affect change. Concerns relating to keeping people safe, protecting them from abuse, minimising restrictions upon people, the staff culture and oversight of the care and support people received to stay safe, had not been recognised, identified and improvements had not been made.

There was no-one receiving end of life care at the time of the inspection. A visiting professional told us that when people were at the end of their lives they were well cared for. Staff ensured they comfortable and pain free.

The service was clean, and measures were in place to prevent the spread of infection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Church lane on our website at www.cqc.org.uk.

The last rating for this service was Good (The last inspection report was published on 07 December 2018).

Why we inspected
The inspection was prompted due to whistle blowing concerns received about the restrictive and controlling culture of the staff. A decision was made for us to inspect and examine those risks.

The provider has taken action to mitigate the risks and we are monitoring the service to ensure the action the provider is taking is effective.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to failing to protect people from avoidable harm, failing to effectively risk assess, failing effectively monitor the service, failing to safeguard people, failing to provide person-centred care, failing to ensure competent and trained staff were deployed at this inspection, failure to supervise and monitor staff and failing to submit statutory notifications to CQC.

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 request an action plan for 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.

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.

Following the inspection we took enforcement action and cancelled the registered managers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Church 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 Care Act 2014.

Inspection team
On 4 July the inspection was carried out by two inspectors. On 10 July 2019 the inspection was carried out by two inspectors

Service and service type
Church Lane is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 4 July 2019 and ended on 10 July 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection in December 2018. This included details about incidents the provider had notified us about, such as allegations of abuse. We sought feedback from partner agencies and professionals.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with members of staff including the operations director, compliance and regulation manager, the locality manager, registered manager, two deputy managers, senior care workers, care workers and agency staff.

We reviewed a range of records. This included five people's care records. Accidents and incidents records. We looked at two staff files in relation to recruitment and staff supervision. We looked at the minutes of staff meetings and the staff communication book.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with partner agencies and professionals including the local safeguarding adults team. We sought more information from the provider including training records, medicine records the staff rota and audits of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

●People were not protected from the risk of abuse.

●Whistle blowing concerns had been raised about how people were treated by staff. Some staff used controlling and restrictive practices. People had been physically, verbally and emotionally abused. As a result of these allegations staff had been suspended from the service to make sure people and staff were safe.

●There was an indication that some staff's abusive attitudes and behaviours towards people had been identified as far back as June 2017.

● We reviewed a staff meeting from June 2017. The minutes of the staff meeting stated, 'All staff should be mindful of how they are talking to the ladies, at times I know we have to raise our voices if the ladies are having behaviours, but it seems that the ladies are at times being shouted at and this is not acceptable.'

●The next staff meeting which was held in September 2018 stated, 'I have had some complaints from people about staff using nick names or calling them names. This is not acceptable, this is upsetting for some of them and they have requested the staff refrain from doing this.'

●The registered manager had taken no action in response to these allegations. These behaviours were not considered as abusive. People told us that the name calling continued.

● Some people told us they did not feel safe living at the service. They said they were scared of certain members of staff.

● One person had unexplained bruising recorded on a body map. There had been no investigation into how the bruising had occurred. It was not documented in any other records.

●Another person disclosed that they had been pushed to the ground by staff. They said they had banged their head and fallen to the ground. Unprompted they showed us a bruise on their leg. They said, "They (the staff) didn't help me get up. I said could I be helped up, they said no you can see yourself up."

●The person said they had reported this to the deputy manager and they said response was, "You did that yourself."

●A whistle blower reported that two members of staff had forcibly tried to remove a person from the lounge area.

● A person told us that staff swore at them. They said they had challenged the staff member and said "I don't swear at you. You shouldn't swear at me", the staff member had replied. "Yes, I can swear."

● Another person told us about when they went out with certain staff. They said, "(Name of staff) makes me walk a very long way before she lets me have a drink or eat anything. I told her, and she tells me off. 'If you keep on saying your thirsty and want to stop for a drink or something to eat you won't come down this town

anymore'."
●People stated that they had reported incidents to management, but nothing was done. One person said, "We get told off for saying things, so I have just given up saying anything".
●Incidents of potential abuse and abuse had not been reported to the local authority safeguarding team.
●All abusive incidents were reported to the local safeguarding authority after the inspection.

The provider and registered manager had failed to protect people from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management and Learning lessons when things go wrong
●People were not consistently protected from the risk of harm.
●A number of people living at the service were at risk of choking due to swallowing difficulties as a result of a medical condition. Several people were under the care of the local speech and language team due to their difficulty swallowing. There was some generic guidance in place in relation to choking but there was no individual guidance for staff on actions to take should a person start to choke.
●There had been a 'near miss' when a person had been at risk in the bathroom. The management team had not undertaken a full investigation of the incident when it happened.
●At the inspection we brought this to the attention of the management team and an investigation was undertaken. The outcome was that the person had been at significant risk and had been subject to neglect. The local authority safeguarding team had not been informed of this incident at the time.
●There were risks around people's health needs not being met.
●Some people were at risk of not having enough to drink. Some people had the amount of fluids they drank monitored to make sure they were drinking enough. Fluid charts were completed poorly. There was no recommended daily amount that the person should be drinking, and no total amount drank for most days. Amounts recorded varied from 200mls a day to 1750mls, but staff were not aware of how much the person should drink. There was no evidence of any action taken when people's fluid intake was low.
●Some people were at risk of becoming constipated. People had been diagnosed and were prescribed medicines to help with this condition. However, risks were not being safely managed. One person did not have a constipation care plan or risk assessment to give staff guidance on how to support them with this health condition. Their prescription for their medicine to help with constipation stated to be given 'if no bowel movement' but did not state after how many days. There was an 11-day gap in April to May where no bowel movements were recorded, and the person had a seizure in this timeframe. There were regular gaps of 3 days or more with no evidence of action taken.
●Some people were diagnosed with epilepsy and had been prescribed medicines in case they had prolonged, or repeated seizures. One person's epilepsy care documents were contradictory and unclear. There was no guidance in place on when to give a second dose of the epilepsy medicine. The information was contradictory and stated in one document 'cannot give a second dose'. Another document stated, 'can give a second dose.'
●Safety checks on fire equipment had not been completed according to the provider's policies and procedures. Checks on the emergency lighting, the fire alarms and fire doors were supposed to be carried out weekly, but these had not completed at the end of June 2019. The area manager assured us they would complete these checks immediately.
●Lessons had not been learnt and action had not been taken when things were going wrong.
●Concerns about the staff culture and attitude had been identified and recorded in the minutes of staff meetings dating back to June 2017 and followed on in subsequent meeting.
●No action had been taken by the provider or registered manager when this had happened.
●The unacceptable culture and attitudes of some staff had continued to develop unchecked.
●The findings from this inspection confirm this is what had happened.

The provider and registered manager had failed to adequately assess, monitor and mitigate risk which placed people at significant risk of avoidable harm. Care and support was not provided in a safe way to people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●At the time of the inspection the service was using high numbers agency staff to cover staffing shortfalls.

●Staff said that there were not enough staff available to ensure people's needs were met. Staff said, "I don't think there's enough staff and people can wait for ages for help. Sometimes it 11am before people are up for breakfast."

●Staff reported that people were not receiving the one to one hours they were entitled to. One staff member said, "There is not enough staff: we need more staff as residents are one to one. One person had 70 hours 1:1 and we can't give that as we're running around after other people."

●There was an entry in the staff communication book that stated there must be a member of staff in the lounge area at all times. People told us this was not the case.

●One person told us about when other people had behaviours that may challenge they did not feel safe. They told us that staff were not always around, they said they went to meetings and people were left unattended in the lounge.

●Another person told us that staff do not put the people they are looking after first. They said, "Sometimes I have to wait to have a shower. Some staff don't help. They are not busy but were talking on their phone."

●On Inglewood staff told us about conflict amongst the staff team. They said that staff argue with each other about what they are supposed to do during a shift. They reported that some staff ignore instructions on what support to give people.

●An entry in the communication book read, "All of our service users should get the same support from all of us, avoiding them or leaving them is not good care."

●On Church Lane staff reported that they all worked well together as a team. They said the deputy manager, based downstairs, was very supportive.

●The provider had followed correct procedures for safe staff recruitment.

●There were up to date documents on file such as, application forms, interviews notes, references and DBS (Disclosure and Barring Service) status confirmation. The DBS checks help employers make safer recruitment decisions and helps to prevent the employment of staff who may be unsuitable to work with people who use care services.

The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

●Medicines were not always managed safely.

●Recently some medicines that were used to ease people's anxiety had gone missing from the drug cupboard. The registered manager said they had discussed this with the local safeguarding team and had been told not to raise an alert.

●The registered manager had undertaken an investigation, but the missing medicines could not be accounted for or found. There was a risk these could have been given to people without a prescription.

●Since this incident more checks and audits had been put in place.

●We discussed this incident with the local safeguarding adults team who told us that they would not have advised the registered manager that this incident would not meet the threshold for a safeguarding referral.

●There was a delay in reporting the incident to the local safeguarding team. A safeguarding alert was raised

by the local safeguarding authority and they informed the CQC of the incident.
●Some people were prescribed medicines to be given on a 'when required' (PRN) basis. These medicines are not needed all of the time, just now and again. These included a medicine to ease anxiety if they became distressed.
●There was no guidance in place for staff to follow for when these medicines should be given to people. There was a risk that people would receive these medicines inconsistently and when they did not need them.
●One person received medicines for when they had a seizure. The PRN protocol for this medicine was contraindicatory and not clear. It stated not to give a second dose but then said no more than two doses in a 24-hour period. There was a risk that the person may not receive enough, or too much, medicine.

The provider and registered manager had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Medicines that people received on regular daily basis were managed safely.
●Staff received training in managing medicines and had their competency checked regularly.
●People's medicines were stored safely in a locked cabinet in their room and the cabinet temperature was checked daily. Records were kept of all medicines that had been given to people, these records were up to date and all medicines had been signed for.
●Medicine audits were carried out daily by trained staff.

Preventing and controlling infection
●The service was clean and tidy and free from any unpleasant odours.
●There was a weekly and monthly schedule to ensure that all areas of the service were cleaned regularly.
●There were infection control systems to mitigate the risk of harm to people and prevent the risk of cross contamination.
●Staff had completed training in infection control. Staff had easy access to personal protective equipment for supporting people with their personal care.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
- Staff were not given the support they needed to undertake their roles effectively and safely.
- Twenty-one staff had not received supervision this year. Therefore, no issues, concerns or developmental needs had been discussed and addressed.
- Issues concerning staff attitudes and staff culture had been identified. No action had been taken to address these with individual members of staff to improve practices and make sure people were receiving effective care.
- Staff practices had not been challenged and addressed even though they had been identified and recorded in the minutes of staff meetings.
- The minutes of staff meeting in September 2018 stated that staff had called people names and they were to refrain from doing this as it was upsetting for people. No further action was taken
- At the inspection people told us that staff continued to call them derogatory names.
- Staff had not received up to date training in keys areas like manual handling, infection control and safeguarding people from abuse.
- We found that incidents of abuse had not been reported and the appropriate action had not been taken by the registered manager.
- People had serious conditions like epilepsy and diabetes. Some staff had not received up to date training for people who had specialist needs like epilepsy. People frequently had seizures due to their condition.
- The training schedule did not include staff training for diabetes. Staff lacked understanding about this condition and had placed restrictions on a person about what they ate and when.
- There was a risk that staff may not take the right action to deal with people's conditions.

The provider and registered manager had failed to provide staff with the training and support they needed to be effective in their roles. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care.
- People had access to health care professionals such as the GP, speech and language therapist, specialist community nurses and care managers.
- People told us they were supported to attend health appointments.

●Some visiting health professionals told us that the staff contacted them when they needed advice and support. However, other specialists who had been involved with the people told that staff had not followed advice and specific plans that had been devised for people.
●Some staff we spoke with were not aware of people's health conditions. One member of staff did not know a person suffered from epilepsy and constipation.
●When people suffered from conditions like constipation, records were not accurately kept to ensure their condition was monitored closely.
●When a person had a seizure, staff had taken the appropriate action at the time and the emergency services were contacted. The person received appropriate treatment; however, staff did not follow this up and seek advice and support from the persons GP or specialist nurse to make sure the person was receiving the treatment they needed.
●Some people were at risk of losing weight due to a poor dietary intake and being very mobile. We found one person who was at risk of losing weight was supposed to be weighed monthly. This had not been done.
●There was a risk that the person was losing weight and if they were no action had been taken.

The registered persons had failed to ensure that all peoples healthcare needs were monitored and take action when issues were identified. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People's physical, mental and social needs were not holistically assessed. People lived with complex needs and the lack of an effective assessment placed them at risk of not receiving the care and support they needed.
●The provider failed to consistently ensure people were supported to achieve their goals and aspirations. Goal setting for people with learning disabilities is recognised as an essential technique to help them feel positive and in control of their lives.
●Staff told us that they bribe people to get them to do what they wanted them too. One member of staff said, "I bribe her and tell her if she behaves she can watch [the person's favourite TV programme]."
●People were given limited choices about how they lived their lives. Staff decided what people would do and when they would do it. For example, when people went to bed and got up, what activities they did. When they could have drinks and snacks.

People were not consistently supported in a person-centred way. The provider was in breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
●People's fluid intake was not always monitored or recorded appropriately. We have reported on fluid intake in the Safe section of this report.
●Staff prepared food and drinks for people, so they had the nutrition they needed. People were not involved in choosing the food they wanted and not always involved in preparing meals.
●The kitchen on Inglewood was locked. People had to ask permission to get drinks and snacks. These were restricted by staff.
●One entry in the staff communication book stated, '(Person) today had cereal and toast and then I went into the dining room she had made herself another bowl of cereal. Apparently, this has happened before.' Staff tried to control what people had to eat. People could not eat the food they wanted when they wanted too.
●The minutes of the staff meeting in April 2019 records, 'The (people) should be offered more drinks throughout the day and not just at set times, the (people) should be able to make drinks when they want

them. (People) should not just be offered one biscuit but be able to choose what they want from the biscuit tin.'

●At the time of the inspection people continued to have drinks at set times and ask permission from staff if they wanted extra. The registered manager had not taken action to ensure the practice had changed.

●Snacks that were kept in the kitchen were out of reach, so people could not access them.

●One person told us that her snacks were removed from her room. When they asked why the staff had said it was in case they choked. The person was not at risk of choking.

●We observed a lunch time meal. Two staff were supporting two people to eat. A third staff joined to help a third person. Pureed meals were served with food pureed separately. Staff told the person what they were giving them before they put the food to their mouth. One staff was talking to the person as they supported them. Other staff were less active and were passively supporting people without engaging them during the meal.

The registered persons failed to ensure peoples nutritional and hydration needs were meet. This is a breach of Regulation 14 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 with appropriate legal authority. 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.

●Staff followed a system to assess people's mental capacity prior to requesting their consent or making decisions on their behalf. MCA assessments had been completed.

● When MCA assessments found that a person lacked the capacity to make a decision there was not always a best interest meeting to decide on the least restrictive outcome.

●Some people had DoLS in place to make sure they were kept safe. However, we found that three of the DoLs had expired and had not been reapplied for. The failure to reapply for the DoLS meant that some restrictions being used were unlawful.

●Following the inspection, the provider informed us that these had been applied for.

The registered persons failed to consistently practice with regard to obtaining and documenting consent for care and support. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

●Parts of the internal and external environment were looking in need of repair and upgrading.

●The providers representative informed us that there was a plan in place to do this work.

●Areas of the service had been adapted to meet people's needs.

●In Church Lane the kitchen had been made accessible for people in wheelchairs. However, people were

not supported to use the kitchen and prepare food and drinks.
- There were hoists and specialist equipment available for people.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Inadequate'.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People had no control over their lives. Staff had control. The service was managed around the needs of the staff, not the needs of the people who lived there.
- Minutes of staff meetings recorded that when people were watching TV in the small lounge area staff had told them to go to bed. This was where the staff sleep-in bed was, and staff had wanted to make their own bed up.
- It was recorded that when staff came on shift at 9:00 am they were sitting down to have their breakfast and not talking to the shift leader about their duties for the day or supporting people with their morning routines.
- It also stated that staff were not to sit around playing on their mobile phones or to sit in the lounge area with their feet on the tables. People told us that staff were often on their phones.
- One person told us that a few days before the inspection they had been watching a TV programme in the small lounge. They said a staff member had come in and turned the TV over without asking them. They said the staff member did not speak to them or acknowledge their presence and left the room.
- People told us at times staff swore at them and used disrespectful language. They said staff called them names they did not like.
- Disrespectful language was used in parts of peoples care plans.
- A member of staff reported that people were told by staff that they were ungrateful. They reported that staff made people get up from bed when they did not want and shouted at them.
- A member of staff stated people were 'told off' by staff for sitting with their legs crossed during a church service.
- It was reported that people were emotionally and psychologically coerced to do activities they did not want to do, with the promise of a cup of tea and biscuit. One person became upset during an activity staff tried to forcibly remove them from the room. When they would not leave they were told they would not get a biscuit.
- The member of staff reported their concerns to the registered manager who took prompt action to notify the local safeguarding team and the CQC. The reported concerns were being investigated
- People did say that some of the staff were kind and caring but others were not.

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

●There was a feeling of restriction. People were not involved in meaningful activities.
●People were not involved in planning their own care. Peoples care was planned by the staff team.
●When people did express their views that were not listened to.
●People told us they did not know what was in their care plans.
●People were not involved in the day to day running of the service.
●People were not taking part in everyday activities like cooking. On the first day of the inspection the kitchen was locked. People told us that staff kept the key. On the second the kitchen was open, and people were able to access it.

●People told us they were not allowed to cook. They said they went shopping but staff choose what to buy. One person said when they lived at home they used to cook but since living at Chapel Lane they had not cooked.
●There were no plans to increase people's skills. Staff were doing things for people rather than with them.
●Staff were not using techniques like positive behaviour support and active support to really get people involved despite their disabilities. Staff expectations of people's abilities lead to limited opportunities for people

The registered persons failed to provide person centred care centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Respecting and promoting people's privacy, dignity and independence
●The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. People were not supported to live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.
●People were not treated with dignity and respect and people were referred to in disrespectful ways both face to face and in their care records.
●People told us that staff called them names that the did not like. People said that staff had sworn at them.
●During the inspection we observed a person asking a member of staff which bathroom they were allowed to use.

The registered persons failed to treat people with respect and dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People's personal information was kept private. Computer records were password protected so that they could only be accessed by authorised members of staff. Written records which contained private information were stored securely when not in use.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as 'Good' At this inspection this key question has now deteriorated to 'Inadequate'.

This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive care that ensured they had choice and control to meet their needs and preferences.
- Peoples goals and aspirations had not been identified. The care plans had not been written with people's involvement and were not produced in a way that was meaningful to people.
- The care plans were not being adhered to. One care plan stated, 'Morning was an important time of day. It takes a while to come around. Needs time and to be left in bed until ready.'
- We received information stating that a staff member woke the person up at 8:30. The person refused to get up. Staff went back a half hour later and got person up saying they could go back to bed after they had their medicines.
- The person was taken to the bathroom and personal care was done and the person was dressed. The person was not co-operating as they were tired. It was reported that the staff member 'just kept going on at them and shouting' at the person.
- Staff said that there were not enough activities for people. They had discussed this at staff meetings. They said activities had not really improved.
- People told us that staff plan activities for them and they are not involved in choosing and planning.
- People said sometimes there are things on the activities plan that they do not want to do. For example, staff held a religious service in the lounge.
- Staff were not happy because people were not enthusiastic about the religious service. Staff told people they would not get tea and a biscuit if their attitude did not improve.
- Staff said, "I don't think people get to go out or do enough. We only have two drivers and if they are not available people cannot go out. We used to have an activities person and every day they were getting out. Since they left it's not happened. The registered manager has not advertised for one. Having an activities co-ordinator would make things much better."
- One person's care plan stated that they needed support to attend hydrotherapy and liked going out in the car with music on. This had not consistently happened. A monthly summary sheet only had two outings in a car in the month.
- During the inspection we observed a lot of people in Church Lane all sitting in the lounge area for a long period of time. There were no activities taking place.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●We observed one person making vocalisations, but staff were not interacting with them.

●People communicated with a range of different abilities and in a wide variety of ways. However, these were not planned for consistently.

●One person used Makaton (a form of sign language) but their care plan did not explain to staff how to use Makaton to help the person to communicate. We spoke to staff and they told us they had not received training in Makaton. One staff said, "[name] does Makaton and she was teaching me it." The management team and staff team were not using visual Makaton symbols or spoken hand signs with the person.

The registered persons failed to provide person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Each person had a care plan which gave information about how to give people the care and support that they needed.

●There was information about people's background, their religious preference and daily routines.

●There were also plans in place for when people had medical condition like epilepsy or were at risk of choking.

●One person told us they went to a farm every week for the day and they enjoyed doing this.

Improving care quality in response to complaints or concerns

●The provider had a complaints policy and procedure in place, but this had not been adhered to.

●People's concerns and complaints were not taken seriously.

●People told us they had complained to the registered manager and deputy, but no proactive action had been taken.

●People had complained about the attitude and behaviour of staff. Some this had been recorded in staff meetings, but no action had been taken.

●One person said, "We are not allowed to moan or complain. I have told the registered manager and deputy, but they told us off for saying things, so I have just given up. We have had enough."

The registered persons failed to respond to complaints according to their policies and procedures. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

●At the time of the inspection no-one was receiving end of life care.

●Some people did have end of life care plans in place which included information about peoples cultural and spiritual needs. Other peoples end of life plans were being discussed with relatives.

●A visiting professional said that people were well cared for and supported at this time of life's. They said that the staff were caring and attentive and made sure people had a comfortable, dignified and pain free death.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Inadequate'.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Concerns were raised with the Care Quality Commission about the staff culture within the service, in that it was not open, person centred and empowering for people. We found this for ourselves at the inspection.
- The culture was one of staff doing for people rather than supporting people to be independent.
- Staff were in control of people, the environment, and in control of what happened day to day.
- People did not consistently receive personalised care. People were not safe from a range of risks to their health, safety and well-being and people were not being safeguarded from abuse. Staff were not deployed safely.
- Quality audits had not been effective. Audits carried out by the provider's representatives had not identified the issues found at the inspection. This was despite records being available which demonstrated some of the concerns (for example, staff meeting minutes) which should have been looked at by the provider's representative during their quality monitoring visits. This had a major impact on people, as they experienced poor treatment which had been noted in staff meeting minutes as far back as 2017.
- A member of staff told us that the registered manager had made derogatory personal comments about them.
- Some staff said they found the registered manager negative. Other staff said they thought the manager was supportive.

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

- The provider did not have sufficient oversight of the service to ensure regulations were met.
- Leadership of the service was ineffective. The provider and registered manager had failed to ensure that people's needs were known and met. This had an impact on people's safety, and the quality of care they received, and their quality of life.
- The registered manager had not effectively identified and managed risk, therefore people were placed at significant risk of avoidable harm.
- The registered manager would have been aware of the culture that had developed on Inglewood. As there was evidence in the staff meeting minutes and people told us they had raised concerns with the management team.

●Staff told us they had raised concerns with the registered manager about conflict and tension within the staff team. There was no evidence that the registered manager had taken action to rectify the situation.
●Staff had not been developed or challenged to improve their practice and poor practice continued.
●Shortfalls found at this inspection had not been identified by the provider's quality assurance systems.
●The governance and audit systems, including the visits and checks carried out by the provider's representatives had not identified that staff were using controlling techniques and not providing person centred support.
●There was a lack of observation and oversight of staff practice. Staff were not given feedback and so the controlling practice continued, rather than think creatively and with innovation about how they might support people to achieve and have an improved quality of life.
●People were not involved in developing and shaping the service. Their opinions and concerns were not listened to and not acted on.
●Following the first day of the inspection the provider had taken disciplinary action without prejudice, pending an investigation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●People were not partners in their care or involved in service developments.
●Surveys had been sent to people, staff relatives and other stakeholders in April 2018. Positive comments. had been received. These included; "Staff respond really well to people's needs." and "Relatives suggestions are always fully supported and encouraged."
●At the time of the inspection surveys had not been sent for 2019.

Working in partnership with others
●We received mixed opinions from professionals who visited the people living at Church Lane. One health professional said the staff worked very well with them. They listen to advise and took action. Another professional said that staff did not listen to their advice.
●There were different healthcare professionals involved with the service including, speech and language therapists, dietician, dentists, doctor's surgery and pharmacies. The service did work with learning disability support services and the local authority.

The registered persons failed to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records. This is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 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
●The registered manger did not take action when it had been identified that there was a negative, controlling culture within the staff team. There were issues with the staff culture in the service such as people being spoken with in an undignified manner and disrespectful way. People's dignity and independence was not promoted and developed.
●A staff member told that us that they had been reprimanded by the registered manager for discussing an issue with the locality manager.
●The registered manager had not reported incidences of potential abuse to the local safeguarding authority.
●The registered manager had not submitted a statutory notification to CQC for several incidents of suspected abuse that we found during this inspection.

The failure to ensure that the Care Quality Commission had been notified without delay of significant incidents is a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 failure to ensure that the Care Quality Commission had been notified without delay of significant incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not consistently supported in a person-centred way. The registered persons failed to provide person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered persons failed to treat people with respect and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons failed to consistently practice with regard to obtaining and documenting consent for care and support.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to adequately assess, monitor and mitigate risk which placed people at significant risk of avoidable harm. Care and support was not provided in a safe way to people. The provider and registered manager had failed to ensure the proper and safe management of medicines. The registered persons had failed to ensure that all peoples healthcare needs were monitored and take action when issues were identified.

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 The provider and registered manager had failed to protect people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered persons failed to ensure peoples nutritional and hydration needs were meet.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons failed to respond to complaints according to their policies and procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to assess,

monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs.