Paramount Care (Gateshead) Limited

Paramount Care (Gateshead Ltd)

Inspection report

The Ropery
Derwentwater Road
Gateshead
Tyne and Wear
NE8 2EX

Tel: 01914618799
Website: www.paramountcareltd.com

Date of inspection visit:
22 July 2021
02 August 2021
09 August 2021
21 September 2021

Date of publication:
06 July 2022

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

About the service
Paramount Care (Gateshead Ltd) is a residential care home providing personal care for up to 20 people with a learning disability and/or autism. At the time of inspection 18 people were living at the home.

People's experience of using this service and what we found
People were not receiving person-centred care that promoted their independence. People's care records did not accurately reflect the support they needed. Care was not delivered safely, as risks people faced were not fully identified, assessed or reviewed which placed people at serious risk of harm.

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 expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of care used at the service did not promote people's independence or choice. For example, one person was unable to access the local community because they had displayed a behaviour which challenged the staff the day before, and another person could not access the community because staff did not know them well enough to support them. Care plans were written negatively. For example, care plans reflected only what people could not do and not what they could do independently. People's choices were not documented, and people's care and support plans were task orientated.

There was a negative staff culture at the service and there was no leadership by the registered manager. People did not live empowered or inclusive lives. People were not involved in their care, and advocate support was not always sourced in a timely way.

Infection prevention and control processes were not followed by staff. People were at risk of infection and COVID-19 as staff were not wearing PPE or wearing it appropriately. The provider failed to address these issues during the inspection process.

Medicines were not managed safely. Policies and processes in place did not provide sufficient guidance or information to allow staff to safely support people with their medicines.

Staffing levels were adequate but the deployment of staff did not always ensure people were supported safely, due to the additional tasks staff had to complete as part of their working day. People did not always receive care from staff who knew them well or were aware of their needs. Staff told us agency staff working with people did not have enough information available to provide safe care as records were missing or not fully completed.

The quality and assurances systems in place were not effective, audits were not fully detailed, and records were not always present. The provider failed to ensure the quality and safety of the service was monitored effectively. Records at the service, including people's care records, were not always present, accurate or reviewed.

The home environment was lacking personalisation and mirrored a clinical setting. The fire risk assessment had not been reviewed since 2017 and the provider could not provide evidence to demonstrate issues identified as requiring action in 2017 had been completed.

Staff did not feel supported by the registered manager or management team. Staff had not received or completed all necessary training required to provide safe care to people. Some staff had worked with people for a long period of time and knew people well. People we spoke with said staff supported them kindly.

Due to the failings identified at the service, the local authority and Clinical Commission Group (CCG) have worked with CQC to provide additional support to the provider to ensure people receive safe care. A private consultancy company is now working with the provider's management team to offer support and guidance to improve the service, recruit new staff and work with the provider to ensure they understand the regulations fully and their responsibilities.

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

Rating at last inspection
The last rating for this service was good (published 10 October 2018).

Why we inspected
We received concerns about the safety of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We inspected and found there were concerns with the care people received and record keeping, so we widened the scope of the inspection to review all of the key questions of safe, effective, caring, responsive and well-led.

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

We have found evidence the provider needs to make improvement. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care, staff training and knowledge, medicines management, person-centred care, promoting independence, infection prevention and control, governance and the leadership of the service.

On 11 August 2021, following our first site visits we imposed urgent conditions on the provider's registration to ensure they complied with government guidance for PPE, monitored and mitigated risk, and to ensure the provider has systems in place to have oversight of risk and infection prevention and control. We found these conditions were not being adhered to on 21 September when we returned to conclude our inspection. The provider had continued to place people at serious risk of potential harm.

Following the inspection we have taken enforcement action against the provider and have cancelled the location from the provider's registration and the home has now closed.

Follow up
We are currently having regular meetings with the provider, the consultancy company and the local authority to ensure people are receiving a better level of care. The consultancy company has been appointed by the provider to take over the day to day management of the service, ensure the safety of people and improve the service. We have requested an action plan from the provider to understand what they will do to improve the standards of quality and safety. We are currently working alongside the provider and the local authority to monitor progress and to make sure safe care is provided to people. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Paramount Care (Gateshead Ltd)

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.

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

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Paramount Care (Gateshead Ltd) 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
We gave the provider short notice of the first date of inspection. This was because it is a small service and we needed to be sure the provider or registered manager would be in the office to support the inspection and prepare people for our visit.

We visited the home on 22 July 2021, 3 August 2021 and 9 August. We returned to the home on 21 September 2021 as part of this inspection due to further risks identified by visiting professionals.

What we did before the inspection
We reviewed the information we held about the service including information submitted to CQC by the provider about specific incidents. 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 sought feedback from the local authority contracts monitoring and safeguarding adults' teams and reviewed the information they provided. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experiences of the care provided. We spoke with 25 members of staff including support staff, team leaders, a deputy manager, a service manager, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included seven people's care records and nine people's medication records.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked this was a suitable communication method and people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with one person which enabled them to tell us their experience.

After the inspection
We contacted two relatives to seek their views on the service and the care provided. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, policies and procedures, were reviewed.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of potential harm as risks were not fully assessed or monitored. Lessons were not learned from incidents placing people at risk of further harm. For example, one person's risk assessment was not reviewed after a serious incident where one person had attempted suicide. The staff, registered manager and provider failed to review the incident or review the risk assessment in place. Certain risks were not mitigated, and the person was able to attempt suicide in the same way on a further two occasions within a short space of time. These two incidents could have been prevented if the risk was reviewed, safety was monitored, and lessons learned from incidents.
- People were at risk of potential abuse as staff did not identify potential risk areas. For example, one person was able to continue to access a potential fire and electrocution hazard. Staff identified the risk but had not mitigated this, which placed the person at risk of serious injury or death.
- Risks to people's health and safety were not always assessed or managed safely. For example, health and safety checks were in place, but the records did not provide assurances these checks were effectively monitored or completed frequently enough to ensure people were not placed a risk.
- The fire risk assessment had not been reviewed since 2017 and the provider could not provide evidence to show the high-risk issues identified from this had been mitigated or removed completely.
- There was no effective oversight in place for monitoring the safety of care provided to people. Accidents and incidents were not analysed or fully investigated to reduce the potential of re-occurrence.

People were at serious risk of harm, as risks associated with people's health and safety, people's well-being and the environment had not been fully assessed or monitored. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

- We raised our concerns with the provider and the local authority. The local authority has provided competent support staff to work within the service temporarily to ensure people are safe living at the home. The provider has given assurances in the form of an action plan detailing what steps they will take and by when to safely assess risk and monitor people's safety.
- People and relatives felt people were safe. One relative commented, "[Person] can't be at home anymore and that's the only place we were happy with."

Preventing and controlling infection

- Infection prevention and control processes were not followed by staff and placed people at risk of harm. We observed staff not wearing PPE or not wearing PPE correctly. The registered manager and nominated individual gave assurances this would be addressed after day one of inspection, but we continued to observe this during all of our site visits.

● PPE was not stored safely at the service and there were no consistent safe areas for putting on and removing PPE. Staff were unsure about how to safely wear PPE and told us they had not received training around this.
● The provider's visiting processes were not followed by staff. Staff were not fully aware of what steps to take when professionals visited the service to keep people safe and prevent the risk of infection. For example, the inspectors had to prompt staff to ask if temperature checks or testing was required before entering the main home and individual units.
● Quality systems in place did not provide assurances that infection prevention and control processes and policies were being followed correctly by staff, and they were being effectively monitored. For example, after the first day of inspection the provider and registered manager assured us they would carry out regular checks of staff wearing appropriate PPE. On the second and third day of inspection, staff were still not wearing PPE appropriately and the provider was unable to evidence checks had been carried out.

Infection prevention and control systems were not robust enough to demonstrate safety was effectively managed. This placed people at serious risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

● The provider responded to our concerns and created an action plan to show how they would safely monitor infection prevention and control practices at the service.
● Each unit was clean, and we observed regular cleaning throughout the inspection.

Using medicines safely
● Medicines were not safely managed. People's medicine care plans did not contain all essential information for staff to follow to safely support people.
● Staff administering medicines had not had their competencies assessed regularly to ensure they understood how to administer people's medicines safely.
● 'As required' medicines, for example paracetamol, were not accurately recorded when they were administered. Protocols in place for staff to follow for these types of medicines did not contain the relevant information to allow for safe administration.
● Medicine audits in place were not effective and did not provide assurances that medicines were managed safely.

Systems for managing medicines were not safe or in line with national guidelines. This placed people at serious risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

● The deputy manager responded positively to our feedback and confirmed they would review all of the issues identified and people's medicine records.
● The CCG have provided support and guidance with regards to safe medicines management to make sure people are safe.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse as staff were not always following the provider's policies or systems. During our inspection we were made aware of an incident where staff used a banned restraint technique with a person.
● Safeguarding incidents were not fully investigated or notified to the CQC by the registered manager. We made multiple referrals to the local safeguarding adults' team during this inspection.

People were not protected from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safeguarding.

Staffing and recruitment

● Staffing levels were safe to provide people with their required level of support, but staff were not sufficiently deployed. We found staff left units without replacement staff which resulted in people not having the correct level of support at times. This placed people and staff at risk. For example, one person's care records stated they required three staff members present at all times, but during the inspection we observed only two staff supporting them at times. Another person who required two staff members to provide support at all times, was only supported by one staff member due to staff taking regular breaks. We addressed this with the provider who assured us the process would change. They told us the management team would go to each unit to support with tasks so staff could provide continued support to people with the correct staffing numbers. However, we found staff were still leaving people with incorrect staffing numbers on our next site visit.

The provider did not ensure there were adequate levels of staff available to safely support people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing.

● Staff recruitment was safe, and the provider had carried out all relevant pre-employment checks.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices were not appropriately assessed in line with best practice guidance, standards and the law. Holistic assessments of people's needs were not completed and care plans in place did not include individual's needs and choices. Records did not show people were asked for their choices around the support they received. We observed people who could fully communicate were provided with choices by staff. However, people requiring pictorial information or easy read information, were not provided with choices. One person's care record showed staff made decisions for them without involvement from relatives, professionals or advocates. This was not in line with guidance or the law. The registered manager confirmed some people required pictorial aids to communicate and understand information, but these had not been sourced for staff to use.
- Care plans were written negatively. They did not promote people's independence and were not regularly reviewed. Care plans lacked person-centred detail and were standardised. People were referred to by their initials or by the wrong name in some care plans. People did not have access to easy read formatted care plans so they could understand the information.
- Best practice guidance and standards were not being followed by staff. For example, we discussed the STOMP initiative (stopping over medication of people with a learning disability, autism or both with psychotropic medicines) with the management team. The registered manager and service manager were unaware of this best practice standard.
- Assessments by other health care professionals were included in people's care records but these were not used by staff to create or develop existing care plans to effectively support people.

People did not have their needs fully assessed or have appropriate care plans in place to allow staff to effectively support them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

Staff support: induction, training, skills and experience

- Staff were not supported by the management team and the majority of staff had not completed all the training the provider deemed necessary to provide safe and effective care to people. For example, we found 10 staff based in one unit where no member of staff had fully completed their training. One staff member had 36 mandatory training modules to complete.
- During the inspection the need for additional training for staff around PPE was identified. The provider failed to provide this to support staff by the date of our last site visit.
- A staff member told us, "We only see [registered manager] when there is a visitor on site. We don't have

supervisions with them, we support each other in the units."
● Staff did not have enough knowledge and information about one person to support them safely in the local community. This meant the person was restricted from going out. Staff told us, "I don't feel confident taking [person] out."
● Agency staff were used to support people and this was not consistent. Staff told us agency staff did not have all of the relevant information available to safely support people as care plans and risk assessments did not include all of the relevant details for staff to follow, and agency staff had not supported the person before.

Staff were not fully supported by the management team and had not completed all the required training to support people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People's care was not delivered in line with MCA and best practice guidance. For example, one person had a best interest decision in place which was made by two members of staff. There was no evidence of involvement from the person's relatives or advocates or other health care professionals. People who were subject to DoLS were asked to consent to their care and treatment when they had been assessed as lacking capacity.
● The provider had not adhered to conditions stated on people's DoLS. People who were under the Court of Protection had expired documents in place which meant people should not have been prevented from leaving the service by staff. We requested a review of people's capacity and the DoLS in place.
● People did not have individual person-centred care plans showing how they are to be involved/supported in decisions about their care or details of who was to be involved in the decision-making process if they were unable to communicate. People who required pictorial information to make decisions were not given these and staff made decisions on their behalf.
● People were locked in their individual units by staff. People who were not restricted to leave the home could not leave the buildings unless a member of staff unlocked the doors. We discussed this with the provider who felt the locked safety gates at the entrance to the home were not adequate to prevent people leaving the service without staff being aware. The provider agreed to review the processes in place, as there was a dedicated staff team in each unit.

People did not have their care and support needs delivered in line with MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Need for consent.

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

● The service was not adapted to meet people's physical or sensory needs. The decoration and overall design reflected a clinical setting and did not include any personalisation in communal areas.

● Staff had failed to make best use of a unit where one person was living alone. Staff restricted the person's movement throughout the unit. They could only use four rooms on the ground floor. Restricting this movement meant this person was unable to access the sensory room and a larger lounge. Staff told us, "[Person] is easier to manage when there's less places to go."

● The units where people lived did not have a homely environment and people had information for staff displayed in their kitchens and dining areas.

People did not have their needs fully met by the design and decoration of the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

● People's bedrooms were personalised which contained their belongings and pictures on the wall.

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

● People received support from staff to maintain a balanced diet. Records showed what people had eaten and drank but did not highlight the choices or the risks for the individual. For example, care records provided an overview that a person was at risk of obesity and staff had raised this with the management team. However no further information was available to see if any action had been taken or if the person had been aware of the concerns around their diet.

● The consultancy company is currently reviewing all people's support needs and carrying out additional assessments to make sure people have care plans in place to support them to maintain a balanced diet.

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

● Staff did not always work with other agencies to provide a consistent level of care, and records showed this was not always in a timely or effective way. For example, one person's records stated if there was any identified self-harm staff should contact the GP or 999 or 111. Records showed on two out of three occasions this had not been followed.

● Feedback provided from visiting professionals was negative around staff engagement with them and their ability to action advice and guidance provided. For example, one professional told us staff were not actioning areas relating to one person's behavioural plan. The professional commented that on follow up visits staff would not review the person with them or make changes to their care plan.

People were not always supported to access other health care services and treatment was not sought in a timely or effective way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

● Relatives told us staff supported people to attend health appointments. One relative said, "They take [person] to the appointments at the hospital."

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.

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

- People were not supported to express their views and we found advocate support was not always sought in a timely manner. An advocate is another person who helps people to express their views and wishes and helps people to stand up for their rights. This meant people's support needs did not include their choices or views and staff were making decisions for them, which may not have been what the person wanted. For example, one person was being restricted from leaving the service and staff were making decisions on their behalf. The legal documents restricting the person's movements had not been reviewed since May 2017 and the person's capacity had not been reassessed.
- For people who could communicate, staff asked them what they would like to do and make decisions about their day. For people who were unable to fully communicate, staff or the management team had not fully explored how to deliver care in line with what their choices would be.
- People's care plans and choices were not available in easy read or pictorial format. The management team acknowledged this and confirmed they would have to order pictorial aides to support people to make their own choices.

People were not fully involved with their care or provided with choices about this. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

Respecting and promoting people's privacy, dignity and independence

- Staff did not promote people's independence or respect their privacy and dignity. The provider was not meeting best practice guidance with regards to respecting people's dignity. For example, Social Care Institute for Excellence details nine standards that should be maintained by staff to respect people's dignity. The provider failed to evidence they were meeting eight out of the nine of the defined standards. For example, one standard relates to the skills and strengths a person has and recognising these. Staff did not focus on what the individual could do but only on what they could not do. This was also documented in care records with no focus on the individual and what they could do independently.
- Care plans did not encourage people to be as independent as possible. For example, one person's care plan detailed a person could behave negatively towards staff if they walked in his room without knocking. The plan in place did not highlight that staff should ask the person if they could enter the room only what steps they should take if the person did not like staff entering without consent. Staff and the management team were unaware that this was not promoting privacy and dignity. The management team assured us this would be addressed. When we returned on the final date of inspection this had still not been reviewed

despite the assurances provided.
● Care records did not focus on what tasks the individual could do but only what tasks staff can do. People were not at the centre of any care plans and staff did not allow people to be independent without staff support. We observed staff were task focused and worked through what they had to complete to support people. For example, one person's care record focused on behaviours that may challenge staff and what action staff should take in these incidents. There was no reflection on what the person could do independently with staff supervisions.
● People we spoke with told us they did have some independence. One person said, "I'm allowed to leave for two hours on my own and this lets me do things for myself."

People were not treated in a dignified and respectful way by staff. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● People were not always treated kindly by staff. During the inspection process one member of staff spoke very negatively and degradingly towards a person in front of them. We asked the staff member to stop the discussion, so the person did not hear what was being discussed. We reported this to the management team who took immediate disciplinary action.
● People felt supported by caring staff. One person said, "I like the staff, they are lovely."
● Equality and diversity policies were in place to make sure everyone was treated fairly, regardless of their age, sex, race, disability or religious belief, but staff were not following this fully.
● Relatives were happy with the support provided by staff. One relative commented, "Can't complain [person's]well looked after and its better than [person] being in a hospital."

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

- The care provided was not person-centred, did not meet people's needs and preferences and was not regularly reviewed. People did not have their independence promoted and individual goals in place for what they wanted to achieve. People did not have choice or control about the care provided to them. The management team confirmed the plans in place did not reflect best practice or were person centred.
- We used 'talking mats' to communicate with one person. Talking mats is a way for people who cannot verbally communicate to provide their feedback via pictorial aids. The person told us they did not like their bedroom or their food. Staff were unaware of this. Staff highlighted the person moved their bed every night, which staff moved back every morning and had not considered the person might prefer their room that way. Staff used the insight from talking mats to change the person's bedroom to reflect their choice of where they wanted their bed. This person was also assessed as being able to communicate with pictorial information. However, staff did not provide pictorial information to include the person in decisions about their care planning.
- People were not included in their care planning if they were unable to verbally communicate. People who did not have capacity to make decisions around some elements of their care, were not included in the planning of the areas they could make decisions about.
- The registered manager and nominated individual provided assurances this would be addressed immediately, and reviews of care plans would be completed. When we returned to the home, we found no action had been taken to address the issues and plans in place had not been updated.

People did not have appropriate care plans in place which were person-centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had their communication needs assessed as part of their initial assessments, but these were not reviewed or used as part of care planning. For example, one person's assessment by their social worker detailed that they had previously communicated using pictorial prompts. The service had not used this tool to communicate with the person.

● People did not have access to information in different formats to help them make choices and involve themselves with their care.

People were not provided with information or choices about their care in a format they could understand. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

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 were not always supported to maintain relationships or attend activities. Care records showed activities and relationships were part of people's support needs. For example, one staff group told us a person was not accessing the local community because of negative behaviours the day before. Another person was unable to leave the service because staff did not feel confident in taking them into the community.
● Some staff knew what people liked to do and tried to support them to engage in activities. For example, one person loved swimming and staff supported them with this prior to the pandemic. Due to the restrictions in place staff had tried to find different activities for the person.

People were not fully supported to develop and maintain relationships to avoid social isolation or attend activities. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

● Relatives were able to visit the service and said staff were always pleasant. Relatives told us due to the pandemic people were not leaving their homes as much. One relative said, "You've got to push him to go out if not he'll just stay in bed all day, but a couple of times I've had to ask if he can go out."

Improving care quality in response to complaints or concerns
● Complaints or concerns were not analysed regularly by the registered manager to identify any areas for improvement. Due to the pandemic relatives had been restricted from visiting people and they were unable to comment if they had any current concerns or complaints.
● Records showed investigations were not fully completed for incidents to prevent further occurrences. Investigations into concerns raised about staff were not fully reviewed or completed.

Concerns or complaints were not fully investigated by the provider. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

● There was a complaints process in place that people, relatives and professionals could request if they wished to make a complaint.

End of life care and support
● There was an end of life policy in place and staff had received training around this as part of their induction.
● At the time of inspection no one was receiving end of life care and support.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider and the registered manager were not aware of their legal responsibilities and did not ensure the service was meeting all of the regulations. During the inspection we identified serious concerns in relation to risk management, infection prevention and control processes, PPE usage, care plan reviews, staff training and quality assurance systems.
- The quality and assurance systems were not effective to monitor the quality and safety of the care provided to people. For example, risks were not monitored with regards to self-harm resulting in three serious injuries to a person which could have resulted in loss of life. Another person had received electric shocks by placing metal objects into live computer components. Staff did not remove the risk or review the risk and this allowed the person to continue this activity which could have resulted in serious injury or loss of life. This incident also posed a high fire risk to other people living at the home.
- The registered manager and service manager told us they had identified all of the issues we had identified during our inspection as part of their review in September 2020 but had not actioned any of these or mitigated any of the high risk concerns. There were no records available to support this. However, their admission of this meant the registered manager and staff had knowingly continued to place people at serious risk of harm since September 2020.
- Records were not present, fully reviewed or appropriate. The provider was unable to demonstrate the care and treatment people received.

The provider did not have effective systems in place to monitor and improve the quality and safety of the service. The management team and the provider failed to ensure the regulations were being met. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

- The provider and registered manager failed to notify the Commission of specific incidents relating to serious injuries and safeguarding.

This is a breach of regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We will follow our processes to consider an appropriate response to this outside the inspection process.

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

outcomes for people
● There was a negative staff culture at the service which impacted on the outcomes of people. For example, people were unable to access the local community because of staff confidence, and staff did not feel supported by the management team.
● The care provided did not reflect the underpinning principles of Right support, right care, right culture. The model of care used at the service did not promote people's independence or choice.
● The service did not have clear leadership to empower staff or people to achieve positive good outcomes. Staff told us they did not always trust other members of staff to deliver care to people.

The service did not have clear leadership or a positive staff culture to allow for positive outcomes for people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

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; Continuous learning and improving care
● When things went wrong, apologies were given to people, but lessons were not learned. These incidents could have been used to improve the service and stop any potential re-occurrences.
● Investigations were not always completed for all incidents. The registered manager failed to share learning with staff from incidents. For example, when one incident occurred the registered manager had not fully reviewed the incident, no follow up actions were identified, and no care plans or risk assessments were reviewed. This resulted in the incident re-occurring on a further two occasions.

The management team failed to fully investigate all incidents and put actions in place to stop re-occurrences. Lessons were not learned from incidents and the provider did not look for ways to improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

Working in partnership with others
● Staff did not always work in partnership with others. Records showed people had involvement from health care professionals and the local community.
● Professionals supporting people told us staff did not engage with them. For example, training around specific PPE usage was offered to staff but this was not taken up.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People who could communicate, relatives and staff were asked for their views on the service annually. Evidence reviewed as part of the inspection did not show if the feedback provided was used to improve the service.
● Staff told us they could provide feedback to team leaders and the management team at any time.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated in a dignified or respectful way. The provider failed to ensure processes and policies in place allowed for people's dignity, respect and independence to be promoted. Regulation 10

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 failed to ensure people were protected from potential abuse. Regulation 13

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 did not receive person-centred care which was responsive to their needs, included their choices, their preferences and promote positive outcomes. Regulation 9

The enforcement action we took:

We have issued a decision to remove the location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's care and support was not delivered in line with the Mental Capacity Act 2005. Information about people's care was not provided in a way that they could understand. Regulation 11

The enforcement action we took:

We have issued a decision to remove the location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider placed people at serious risk of harm by not identifying, assessing and mitigating risk. Medicines were not safely managed. People were exposed to potential risk by staff not delivering restraint legally.

The enforcement action we took:

We have issued a decision to remove the location from the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection prevention and control processes were not followed by staff. Risk assessments were not fully completed or reviewed when incidents occurred. The provider failed to have full oversight and to monitor accidents, incidents and safeguarding incidents. Regulation 12

The enforcement action we took:

We have imposed conditions on the provider's registration to ensure people are protected from the risk of potential harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems in place to monitor and improve the quality and safety of care provided. The management team and the provider failed to ensure that the regulations were being met. The service did not have clear leadership or a positive staff culture to allow for positive outcomes for people. Records were not fully completed, reviewed or present. Investigations were not fully completed and follow up actions were not completed. Regulation 17

The enforcement action we took:

We have issued a decision to remove the location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have full oversight and to monitor accidents, incidents and safeguarding incidents. Regulation 17

The enforcement action we took:

We have imposed conditions on the provider's registration to ensure people are safe from the risk of potential harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not fully supported by the management team or had completed all of the required training to support people. Staff were not deployed correctly at all times resulting in people not having adequate staffing levels to support them. Regulation 18

The enforcement action we took:

We have issued a decision to remove the location from the provider's registration.