Leonard Cheshire Disability

Alder House - Care Home Physical Disabilities

Inspection report

Lambourne Road
Chigwell
Essex
IG7 6HH

Tel: 02085008491
Website: www.leonardcheshire.org

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Alder House - Care Home Physical Disabilities is a residential care home providing personal and nursing care to 21 people at the time of the inspection. The service can support up to 22 people.

People's experience of using this service and what we found
We were not assured the service understood or met the principles of right support, right care, right culture. When we arrived the registered manager told us there were five people with a learning disability, following a review of records the registered manager asked people's GP for this information and we were told there were 12 people with a learning disability at Alder House - Care Home Physical Disabilities.

Based on our findings at this inspection. The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support
- Care records did not always evidence if less restrictive options had been explored prior to restrictions being in place or who was consulted in people's best interests.
- The registered manager was not aware how many people with a learning disability were being supported.
- Risks to people's health and wellbeing were not always assessed, monitored and managed effectively.
- Improvements were needed to ensure the service was well maintained and easy to clean.
- Limited evidence was recorded to demonstrate how staff supported people to achieve their aspirations and goals.
- Whilst activities were available for people there was limited evidence of individual plans for people to pursue people's individual interests or identify opportunities for these to be pursued.
- Improvements were needed to medicines management.

Right Care
- Care and support did not always reflect current evidence-based guidance, standards and best practice to meet the needs of people with a learning disability. The provider had recognised this and had plans in place to deliver training on right support, right care, right culture.
- We were not assured that all staff were appropriately skilled to meet people's needs and keep them safe.
- Staff had training on how to recognise and report abuse, however more work was needed to ensure staff knew how to apply this training. Systems to safeguard people were not robust.

● Improvements were needed to ensure people had access to information in a format that was suitable for them. We did see some people had access to communication aids.
● We have made a recommendation about records related to end of life care.

Right culture
● Significant concerns had been identified which had impacted on the service provided. The provider had recognised these failings and additional support had been put into place.
● We were not assured that people were being supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have.
● Staff turnover had been high, which meant people were not always receiving consistent care from staff who knew them well.
● There was limited evaluation of the quality of support provided to people which involved the person, their families and other professionals as appropriate.

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

Why we inspected
This inspection was prompted by concerns that had been identified by the local authority in relation to infection control, medicines management, risk and the culture in the service. We initially did not inspect this service to assess that the service was applying the principles of Right support, right care, right culture as we were not aware that people with a learning disability were supported at the service. When it was identified that people had needs associated with their learning disability, we did inspect this area.

As part of CQC's response to the COVID-19 pandemic we are looking at how services manage infection control and visiting arrangements. Initially we undertook a focused inspection to look at safe and well led. We inspected and found concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to monitor the service and will take further action if needed.
We have identified breaches in relation to mitigating risks, safeguarding people, consent and overall governance and culture of the service at this inspection.

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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in safe findings below.

Is the service effective?

Requires Improvement

The serve was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always 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.

Alder House - Care Home Physical Disabilities

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 completed by two Inspectors.

Service and service type
Alder House - Care Home Physical Disabilities 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.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

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

During the inspection
We spoke with seven people who used the service. Where people were unable to talk with us, we used observation to help us understand their experience of using the service. We spoke with ten members of staff including the registered manager, the regional support manager, the onsite physiotherapist, the organisations back care specialist and support staff.

We reviewed a range of records. This included 10 people's care records and numerous medicine records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with four relatives and two professionals who had knowledge of the service.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● People were exposed to risk of harm as their care needs and associated risks had not been routinely assessed, monitored and mitigated.

● Not all support plans were detailed enough to inform staff about the controls in place to mitigate risks to people and contained conflicting information. For example, formal risk assessment tools were being used incorrectly to determine people's risks relating to their skin integrity and nutrition.

● For one person there were no repositioning charts in place to provide assurance the person was being moved at regular intervals to alleviate pressure to mitigate the risk of poor skin integrity.

● Support plans included waterlow action plans (skin pressure risk). For one person this scored 1. This score is more associated with a screening tool for nutrition and not skin care. The record went on to record information related their nutritional needs. This meant we were not assured staff understood what they were monitoring.

● Risk assessments related to people's choking risks was also conflicting. Information within the support plan stated that food should be fork mashable and then guided staff to cut food into small pieces but did not contain any information about how the risk to people was mitigated if food was cut up this way.

● Personal emergency evacuation plans had recently been updated but not all information recorded was accurate as another person's name was recorded within the text, this did not reassure us that these plans were individual to the person.

● Fire drills had been carried out at the service. However, no information was recorded to confirm if individual staff had attended a fire drill at the service. This meant we were not assured all staff would know what to do in the event of a fire evacuation.

● Accidents and incidents were recorded, but there was no specific detailed analysis to identify any trends or themes. Information recorded did not always record if the accident or incident had been escalated appropriately to the safeguarding authority

Using medicines safely

● Safe medicines practices were not consistently followed. Stocks of medicines did not match records. Whilst a weekly reconciliation check was completed by staff, we still identified issues with stock reconciliation. This meant we were not assured that people were receiving their medicines as prescribed.

● Two people were having their medicines administered covertly. Covert administration is the term used when medicines are given in a disguised format, e.g. in food, drink or via a feeding tube without the knowledge or consent of the person receiving them. There was no risk assessment or guidance in place for staff to do this safely or whether other professionals had been consulted in this was in the person's best

interest. Following the inspection, the registered manager sent us information related to advice given about what medicines could be crushed safely for one person.

Preventing and controlling infection
● We found concerns with the environment in relation to infection control practices. For example, on arrival at the inspection on 4 May 2022 there was discarded Personal Protective Equipment (PPE) by the outside bin area. We informed the registered manager, but no immediate action was taken to rectify this. When we left the service that evening the discarded PPE remained on the floor in the external bin area.
● The flooring in bathrooms around toilets was lifting in several places or not sealed around toilet areas. Flooring should be heat sealed at seams/edges to prevent the accumulation of dust and dirt and facilitate cleaning and reduce the risk of infections spreading.
● An infection control audit had been carried out by the local Clinical Commissioning Group (CCG) which had generated an action plan for the service to address. Some areas had been addressed in relation to signage and bins with lids, but other areas highlighted had not been actioned.

Systems were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service supported visits for people living at the service in line with current guidance and prevented visitors from catching and spreading infections. One relative told us, "They have always asked us to wear PPE and take lateral flow tests before visiting, I think they took COVID 19 very seriously."

Systems and processes to safeguard people from the risk of abuse
● People were at risk of abuse and improper treatment because the registered manager failed to notify the local authority and CQC of safeguarding incidents at the service. For example, the local authority identified concerns had been raised by two people at the service in relation to staff attitude towards them. Whilst this was dealt with as a complaint, this was not escalated as a safeguarding referral. We also identified an accident that met the threshold for a safeguard. The registered manager told us they would escalate this to both the local authority and CQC. Following the inspection these concerns were raised retrospectively. The provider had also employed a consultant to oversee the service to ensure all concerns are escalated immediately.
● A relative we spoke with told us they were concerned that the person's mobility equipment was not being used effectively and despite communication with the service this had not been resolved. We raised a safeguard about this concern.
● Staff had training on how to recognise and report abuse and they knew how to apply it. One staff member told us, "If I had concerns, I would report to the team leader/ manager, if they were not taken seriously, I would escalate higher, anonymously to the local authority or CQC."
● Whilst most staff felt able to raise concerns to the registered manager, some staff felt if concerns were raised with some team leaders, their concerns were sometimes dismissed as not important. We informed the registered manager of this feedback. They told us they were aware and were monitoring this.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems and processes in place to safeguard people from abuse were not robust.

Staffing and recruitment
● There were enough staff deployed. However, we not always assured staff had the right competencies and

skills to support people with specific needs.

● Competency assessments were not up to date and whilst following the inspection the registered manager did send us updated competency assessments for medicine administered via a Percutaneous Endoscopic Gastrostomy) feeding tube (PEG).

● There was no recorded training or competency assessments for staff supporting a person with an aerosol-generating procedure (AGP). The regional support manager told us they were completing a risk register to identify what clinical competencies staff required and these would be updated.

● There was a significant use of agency staff and insufficient information to confirm if agency staff had the appropriate skills and experience. We found the provider did not have up to date profiles for three agency staff and therefore could not be assured they were suitably trained and experienced to support people at the service.

● Recruitment checks were undertaken on staff, including references from previous employment and Disclosure and Barring Service (DBS) checks. However, we found DBS checks were quite old and there were no records of annual criminal declarations in place.

Learning lessons when things go wrong

● Following the visit from the local authority and their own audit of the service the regional support manager had recognised the failings at the service. They had requested additional resources from within their organisation and various support teams were at the service. A learning disability support team, the human resource team, a team from another area and clinical support were assisting the registered manager during our inspection to address the identified shortfalls. The regional support manager was open and honest about the concerns within the service and acknowledged they had work to do on systems and the culture at the service.

Requires Improvement

Is the service effective?

Our findings

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

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

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

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Mental capacity assessments were not always in place for restrictive practices. One person had capacity assessments completed for daily activities but not for the person's bed rails or lap belt.
- On day two of our inspection a mental capacity assessment had been created for a person with restrictive practices in place. There were multiple decisions on one mental capacity assessment. Mental capacity assessments should be decision specific.
- Where capacity assessments were completed, these did not explore or consider if less restrictive practices had been considered or evidence who had been consulted to evidence this was in the people's best interests.
- There was no accurate or effective overview in place to monitor if deprivation of liberty authorisations were about to expire. One application for renewal was only applied for on the day of expiry. This meant we were not assured that people were not being deprived of their liberty without authorisation as capacity information was confusing.
- Most people's consent information recorded, "Unable to sign" but failed to identify if other methods to ensure consent was in place had been considered.

Failure to follow the principles of the MCA was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● The service was using agency staff to maintain safe staffing levels to support people. However, as stated in Safe, records relating to induction, skills, experience and training of agency workers were not always maintained.
● The registered manager sent us the training plan for staff at Alder House - Care Home Physical Disabilities. Whilst this plan did record that e-learning refresher training had been completed, it was not clear what this training covered. There were gaps in relation to specific subjects as it did not record what had been completed in the refresher training. For example, not all staff had received training to support people with a learning disability and no records were in place to evidence staff had received training in relation to specific equipment at the service.
● There were mixed views from staff about whether they had a supervision recently and records confirmed this had not been taking place consistently. One staff member told us, "Supervisions, I have not had one for a while." Another staff member said, "I think I had one a month ago." One staff file we looked at indicated that a supervision had not taken place since 2020.

Supporting people to eat and drink enough to maintain a balanced diet
● People's support plans were not clear about people's individual diets.
● One person's support plan recorded the person was to have a bite sized diet. The person's relative told us they were receiving pureed food and staff were assisting [person] to eat. The relative went on to add that [person] with the right cutlery and equipment was able to eat with support but this was not happening.
● Other support plans related to people's nutrition were unclear as recorded in safe section. With both fork mashable and bite sized pieces recorded within the same support plan. Whilst the new guidance within IDDSI Standards has changed from fork mashable to soft and bite sized, the guidance in the support plans did not go into enough detail to ensure staff were following this recognised guidance correctly. International Dysphagia Diet Standardisation Initiative (IDDSI) is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings.
● During the inspection we observed mealtimes. Interaction with people and staff was mixed with some staff chatting with people whilst other staff assisted people to eat with limited conversation or interaction.
● People we spoke with were positive about the food. One person told us, "I am on a soft diet and I am having lasagne today, we do get a choice." Another person said, "Most of the food is okay. I am not a big eater, but we do get a choice of food." People confirmed they were involved in choosing their food.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's support plans and risk assessments did not always contain enough information to guide staff on how to provide a person-centred service.
● The provider and registered manager had not kept up to date with current guidance such as Right Support, Right Care, Right Culture and this had not been embedded in staff practice at the service.
● Support plans contained limited detail about people's goals and aspirations. Goals recorded were mainly related to people's care needs rather than their aspirations. There were no records to record the progress people had made to achieving the goals recorded.

Adapting service, design, decoration to meet people's needs
● The service was on one level which meant people could access all areas of the service including the garden and we observed people moving around the service independently.
● Some parts of the environment required attention. Several walls had been damaged by wheelchair use and most of the paintwork throughout the service was chipped and damaged. The regional support manager told us this had been identified and would be addressed.

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

● People did not always have timely or appropriate access to health support.

● People's support plans recorded people's oral healthcare needs, including that an annual dental check was required. Whilst some services were delayed due to the pandemic there was nothing recorded to evidence how this will be addressed.

● Two support plans did not contain a record of people's last dental appointments and one person's last recorded appointment was 2020. We did note that monitoring charts were in place to record people were supported with their oral hygiene.

● Hospital passports (a document to aid healthcare professionals understand people's needs) were in place.

● The service had an onsite physiotherapist who provided people with physiotherapy support once or twice a week depending on their needs. They told us, "I see about 12 people regularly most weeks, some of them therapy is once or twice a week. They would like two sessions but usually get one. The majority of my time is for physiotherapy."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Prior to the inspection concerns had been raised about the culture of the service. For example, staff had used inappropriate language in a training session organised by the local authority. The registered manager had taken some action. The regional support manager was aware of the concerns and had organised additional training and support for staff. Meetings were being held with people at the service, relatives and staff to seek people's views and take action to address the concerns.
- People told us they received little input from their key workers. One person told us, "Not really much support but they are trying to do this now." A Key Worker is a named member of staff who has a central role in respect of a particular person.
- One person told us they were not always happy with some agency staff as they did not always know what to do to meet their care needs. They said, "The permanent staff do a wonderful job, but we are getting a lot of agency staff, some of the them are useless." The person did go on to say that it has been better recently and [person] is happy to inform the management team when a concern arises.
- Relatives we spoke with were concerned about the laundry arrangements in place and said they reported things missing but this was not always followed up by the management team.
- One person told us, "It is okay here and I get help I need it. I find staff are caring." Another person said, "I love it here and staff are very good to me." A relative told us, "[Person] is very happy at the service

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

- Support plans did not always evidence people were involved in decisions about their care and support. There was no record of regular reviews or feedback from people about whether their views, goals and aspirations were still current.
- More recently meetings for people at the service had increased and contained more information in relation to involving people in the service and seeking their ideas and their responses to proposed changes at the service. For example, one person had suggested about service information being available to people in their own rooms. During the inspection this was being put into place.

Respecting and promoting people's privacy, dignity and independence

- Most people we spoke with told us staff were kind and respected their privacy. One person said, "Yes staff do knock on my door." A relative told us, "They are respectful towards people."
- Some people were able to go out independently, however support plans did not record people's progress in relation to maintaining their independence. A relative told us they felt staff did not encourage people to

be independent.

Requires Improvement

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 deteriorated to requires improvement.

This meant people's needs were not always met.

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

- Support did not focus on people's quality of life outcomes; goals were not meaningful, and people were not supported to understand how they could achieve them.
- There was no detail about how goals were going to be achieved or regular meetings to review people's progress to achieving these goals.
- Goals were often related to physical care and for some people's goals, questions in the support plans were left unanswered. One person had a goal to increase their mobility and movement, but this had not been reviewed or updated since 2020.
- Most support plans had not been reviewed recently. However, we saw that support plans contained lots of post it notes from a recent audit by the organisations support team to identify concerns with out of date and conflicting information.
- Improvements were needed in relation to monitoring charts in areas like catheter care, repositioning and food and fluid charts. We saw that some of these charts had been introduced and were in people's rooms. However, information was not always kept secure and some charts were seen outside people's rooms.

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.

- Peoples communication needs were recorded as part of their support plan with guidance available for staff. For example, one person used a communication aid to operate their television and demonstrated this for us during the inspection.
- Whilst people's communication needs were recorded, they often required a review, so we were not assured staff had the most up to date information.
- The registered manager told us they recognised that some people required more accessible information for support plans and service information, and this was being reviewed alongside their support plans.

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

- . Whilst there was an activity programme in place it was not always specific to people's individual needs.

There were no individual activity plans in place for people

● Four people had specific one to one care hours in place. The records we looked at to evidence how these hours were being used were poor. A tick sheet was in place with a list of activities that included, walking indoors, walking outdoors, dancing, using musical instruments or playing instruments. Whilst rotas demonstrated staff were allocated to each person, we were not assured these hours were being used effectively or in a person-centred way.

● We saw evidence people were supported with some activities. An activity room was used and on the first day of inspection people were attending a church service. The activity team had a programme in place that included wheelchair dancing, gardening, arts and crafts and games.

● The activity organiser told us they had tried to design the programme around people's choices and talked to people about what they liked to do. The other activity organiser worked as a DJ and often played music to entertain people at parties and events. One person said, "We have activities, colouring, drawing, painting and making things. We also go out on trips."

● Two minibuses were available so people could access the community, go shopping or be supported on their one to one hours. However, issues with specific key workers and staff authorised to drive did impact on people accessing the community. The activity organiser told us, "We do a lot here, certain people we do ask but they do not want to go out. One person goes to the pub, another person goes out for their one to one. We go to the theatre and other events."

● The activity organiser supported people to attend appointments as a driver which had impacted on activity provision but told us a new driver had just been recruited so this should improve.

Improving care quality in response to complaints or concerns

● Not all complaints had been recorded. When we spoke with relatives, we were told of issues relating to laundry, food provision and concerns about staff attitudes. Whilst relatives told us some of these concerns had been addressed by senior staff, we were not assured all complaints were being recorded to be able to analyse complaints or concerns to identify any themes or trends or to discuss with staff as learning opportunities.

● There was mixed feedback about the response to complaints. One relative told us, "The concern I had was absolutely dealt with by the home." Another relative told us, "I did discuss the evening meal, and this was addressed by the home." A third relative said, "I ask staff about something and get a different answer from different staff members. I have emailed the service and do not always get a response." A safeguard was raised in relation to this feedback.

End of life care and support

● No-one was receiving end of life care at the time of this inspection.

● Some support plans had information related to people's preferences and wishes at the end of their life; other support plans contained limited information Further work was required to ensure information relating to people's end of life wishes and preferences was captured and reviewed. For example, one person's wishes had not been reviewed since 2019 to ensure this remained accurate.

We recommend the provider seeks advice from a reputable source about end of life care planning.

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

- Quality assurance and governance arrangements at Alder House - Care Home Physical Disabilities were not effective in identifying the shortfalls in the service.
- We found the risks associated with people's care needs were not reviewed and updated in a timely manner leaving people at potential risk of harm. Support plans were not person centred and there was little evidence people or their representatives had ongoing input into the support planning process.
- Systems and processes to assess, monitor and improve the quality and safety of the service were not effective. For example, infection control audits had not identified the concerns found by both the local Clinical Commissioning Group (CCG) and the Care Quality Commission.
- The registered manager was not following the principles of the MCA when making decisions in people's best interests because support plans did not evidence who was consulted, or robustly follow the processes needed to ensure people were not being deprived of their liberty without authorisation.
- Gaps in staff recruitment, training and competency assessments, agency staff profiles were found.
- The culture of the service did not demonstrate staff were valued, that people's individuality was promoted, and their rights respected so people could develop and flourish.
- Concerns had been raised about some staff attitudes towards people and the provider acknowledged they had work to do to improve the culture in the service. The provider had deployed various support teams and clinical staff from within the organisation to support the service to make improvements.
- The provider had not sent an updated statement of purpose to CQC to inform them that they were supporting people with a learning disability. Whilst people did have physical disabilities, the registered manager had not recognised that people also had needs associated with their learning disability.

Effective systems to monitor and improve the quality of the service, were either not in place or robust enough. This demonstrated a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The regional support manager and registered manager were open and honest about the concerns

identified at the service.
● Concerns were identified in accident and incident records that had not been reported to the local safeguarding authority or CQC. The registered manager reported these retrospectively following the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Meetings had increased as a result of the concerns identified and people we spoke with confirmed they were aware of proposed changes at the service and had been asked for their views. One person told us, "There have been a few meetings and they are keeping it clean. The cleaners now are better than we had before."
● The regional support manager said, "We do understand the issues with culture, and we have the human resources team on site to support the registered manager."
● The provider had put on additional team meetings following concerns raised. A daily meeting had also been introduced to improve communication at the service.
● We received mixed feedback from staff. A staff member told us, "I feel staff morale is ok, initially when I first joined there were a lot of cliques within the home, but this is improving." Another staff member said, "Staff morale is not very good at the moment, this used to be a good place to work. I am happy there is support in the home now."
● Staff were positive about the registered manager. One staff member said, "Our manager is lovely and very fair, we do have staff who care." Another staff member told us, "I do feel supported and I am not afraid to speak up."

Working in partnership with others
● The service was currently working with the local authority and an action plan was in place.
● Support plans did evidence that the service was working with health and social care professionals which included, GP's, district nurses and social workers.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes in place to safeguard people from abuse were not robust.

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 11 HSCA RA Regulations 2014 Need for consent Failure to follow the principles of the MCA was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems to monitor and improve the quality of the service, were either not in place or robust enough. This demonstrated a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The enforcement action we took:

Warning notice