ROCCS Residential Community Care Services Limited

Brent Cottage

Inspection report

Admirals Walk
Hoddesdon
Hertfordshire
EN11 8AB

Tel: 01992467450

Date of inspection visit:
15 March 2022
22 March 2022
13 April 2022

Date of publication:
05 September 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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
Brent Cottage is a residential care home providing personal care to five people with a learning disability and/or autism at the time of the inspection. The service can support up to five people.

People's experience of using this service and what we found

Right support
People were not always receiving support in a way to maximise their independence, learn new skills or enhance their existing skills. Information given to people about their care and support was not always done consistently to enable them to make informed choices about the support they received.

People were not involved in decisions about what information could be shared about them with their relatives or other visitors. People were not supported to play an active role in maintaining their own health and wellbeing.

Staff knew people well and were knowledgeable about triggers to behaviours which put people and others in danger. However, there were no support plans in place to prevent these behaviours.

Staff respected people's choices and supported them in the least restrictive way possible.

Right Care
People were not always supported by a service that had safeguarding systems in place to report and respond to accidents and incidents. We found instances where there were safeguarding concerns, and these were not reported to CQC or local safeguarding authorities. Leadership was not effective and did not identify that people were put at risk or subject to potential abuse.

People's care, treatment and support plans were not reflective of people's needs. People had limited choices in pursuing activities or hobbies they had.

Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs.

Right culture

The provider failed to ensure staff received appropriate training and support to understand people's individual needs and provide enabling support to people. The support people received was not in line with current best practice guidelines. We found evidence of a closed culture in operation.

Risk assessments in place were not encouraging positive risk taking for people, were not evaluated and measured at regular intervals to assess their effectiveness.

Rotas for staff were not planned to factor in the one to one support some people were assessed and funded for. Staff were not aware in all instances how many staff were required to support people safely when they went out for walks or into town.

There was a lack of appropriate planning and records kept showing how involved people were in planning their own support, what outcomes they achieved and what goals they had in life. They had health professionals and social care professionals supporting their care, however no consideration was given if people would benefit from the support of an independent advocate.

The provider failed to develop effective governance and quality assurance system to assess the quality and safety of the support people received. There were lack of audits and actions taken when things went wrong. Actions were not always documented, and it was unclear if actions were completed. This meant improvements were not always made to improve the care people received.

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 inspection for this service was not rated (published on 30 April 2021). The last rating for this service was good (published on 28 June 2019).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right Support Right Care Right Culture. We received concerns in relation to how staff reported safeguarding concerns, how the registered manager responded to allegations of abuse and people had not received support in a personalised and safe way. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. 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 safeguarding people from abuse, safe care and treatment, staffing skills, personalised care and support and governance systems at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service 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.

Brent Cottage

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
This inspection was carried out by one inspector and a member of the CQC medicines team.

Service and service type
Brent Cottage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Brent Cottage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post, however they were away from the service.

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

During the inspection
We spoke with one person who used the service and two relatives about their experience of the care provided. We spent time observing two other people who did not want to speak with us, however they were communicating with staff in the service.

We spoke with four members of staff including 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 four people's care records and medication 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 met with social care professionals to seek their feedback about the service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Safeguarding processes were not fully embedded in the service. Staff training had lapsed and whilst they told us they would report concerns to their managers, they failed to recognise where people were subject to verbal, physical or psychological abuse. This culture allowed incidents of abuse to continue with little management or protection for people who used the service.
- The registered manager failed to report to the local safeguarding authority or CQC, safeguarding concerns staff made them aware of. For example, staff raised concerns in their supervision about other staff's behaviour which put a person at serious health risk. This was reported in October 2021 however, action was only taken in March 2022 when the provider was made aware of this and the registered manager was away from the service.
- Incidents where people physically hurt others were not reported, and no plans were in place to try and prevent these. A person reported that a member of staff pushed them. The registered manager investigated this, however they failed to implement any protection plan or report to the local authority or CQC.
- Where concerns were raised to the local authority and a protection plan was put in place, when we inspected, we found this had not been followed. CQC took action to ensure this plan was followed.
- There were no lessons learnt process in place for incidents or accidents to be discussed with staff or discussions with staff about improving the support people received. As a result, we found that incidents re-occurred for a period of time and actions were only taken after CQC alerted the provider about concerns received from the general members of the public.

Safeguarding concerns were either not identified or notified to the appropriate organisations. This placed people at risk of harm. This was a breach of Regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- Risk assessments were not in place for all identified risk to people. For example, a person's care plan detailed their physical disability could cause them to fall when they were walking. There were no risk assessments in place to establish how high the risk was for the person to fall and what actions staff needed to take when supporting them.
- Risk assessments in place had not fully explored actions to lower the risks and keep people safe. For example, a health professional raised concerns with staff about a person's weight gain and the serious impact this could have on their health. The risk assessment in place identified the health risk to the person but failed to provide staff with an effective plan on how to support the person with healthy meal choices.
- The person had gained a significant amount of weight on since September 2021 to March 2022. The food intake records evidenced that the person continued to have foods which could contribute to their weight

gain. Staff told us they were discouraging the person from having unhealthy snacks but not about their meals. The nominated individual told us they already observed an impact on the person's mobility as they were unable to walk longer distances. The person's relative wrote to the service with their worries about the person's diet, their high blood pressure and the lack of physical activities offered to the person. They asked for staff to arrange swimming again for the person, however this had not happened.

● Information to support the safe administration of medicines was not always present or not clear in people's care plans and medicines administration records (MARs). For example, one person had been administered as and when needed medicines (PRN) to manage their behaviour. However, the associated MARs for the medicine was not in place at the time of inspection and therefore we could not be assured that these medicines were still prescribed by the GP. PRN medicines were handwritten onto MARs by staff and it was not always clear in care plans if the PRN medicines continued to be authorised by a prescriber. Staff later confirmed these were still prescribed for people.

● Handwritten amendments were made to printed MARs. There were no signatures to identify who was making the amendments on the MARs and there was no second signature to confirm what professional instructed the change . Medicine audits in place were not identifying any concerns with medicine management.

Safety concerns were not consistently identified or addressed. This placed people at risk of harm. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People and relatives told us they felt safe. One person answered, "Yes" when we asked if they felt safe and happy living in the home. One relative said, "I feel [person] is safe and happy there." Another relative told us, "Staff are keeping [person] very safe. I am very happy with how they look after [person]."

Staffing and recruitment

● There were not enough staff to ensure people were supported in line with their funding arrangements and wishes.

● The staff rota did not show that enough staff were deployed on each shift to cover people's one to one support hours funded by the local authority. For example, a person received funding for three hours one to one support for activities. This was not planned, and the person had not received this.

● Staff were not aware of safe staffing numbers required when supporting people part of a group activity in the community. For example, a person had been assessed as requiring one to one support in the community or two staff to support three people when they were out in a group. On the day of the first inspection visit there were two staff members supporting four people and a pet to go out which was not in line with their risk assessment and put people at risk of harm.

● We found two instances where one staff member carried out a sleep-in duty during the night when they were allocated to working night duties. This was in place to keep people safe. We raised this with the provider who assured us they would re-iterate to staff about the working nights.

● On the day of the inspection visit a person asked staff to go out for dinner. Staff told them they cannot promise this could happen as they were not sure they had enough staff to accommodate this.

● The provider told us they had some members of staff absent at the time of the inspection and they used some agency, however people were put at risk of not having their needs met due to lack of staff.

● Recruitment processes were not robust enough. Pre-employment checks were carried out, however references were not verified. We found one example where the reference received was not signed by the referee. Gaps in employment were not explored and the criminal record check reference number was not recorded in staff files. This meant we could not check if these checks were carried out. Staff told us they had been asked to provide references and a criminal record check was done before they commenced

employment.

The lack of staff to meet people's needs and unsafe recruitment process was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Some areas in the home, for example the communal bathroom floor, was scratched and black mould observed around the bathtub. This presented an infection control risk.
- It was not always possible to keep social distancing in the service as people liked to touch and feel staff. We asked some staff members to ensure they were wearing their masks correctly when we visited.
- The service was admitting people safely to the service.
- The service tested for infection in people using the service and staff.
- The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
- The service's infection prevention and control policy were up to date.
- The service facilitated visits in line with the current guidance.

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 now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received training to understand the principles of Right Support, Right Care, Right Culture guidance. As a result, the staff team were not supporting people consistently and effectively to help people achieve positive outcomes, learn new skills and plan for the life they wanted to live.
- Staff supervision was in place, however, this had not included personal development plans or discussions about best practice. The registered manager failed to ensure the staff team were skilled and knowledgeable to support people's health and social needs.
- Staff received induction training when they started working for the service, this included subjects considered mandatory by the provider and covered areas including safeguarding, moving people, infection control and others. These training subjects are only valid for a number of years and there is an expectation of providing staff with refresher training to ensure their knowledge is current. Staff had not received refresher training in these areas or other training relevant to their roles.

The lack of suitably qualified, competent, skilled and experienced staff to meet people's needs was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt supported by the provider. One staff member said, "I do feel supported. [Name of provider's representative] is very approachable."

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People were not supported to have an active role in maintaining their own health and wellbeing. People had their annual health checks. However some people were refusing some of the recommended tests for early screening for some conditions they could develop. Staff failed to implement a support plan to ensure they repeatedly gave people the right information in the right way for them to understand the importance of these tests.
- Staff recorded people's food preferences in their care plans and kept a log of what meals people were eating. There were no plans developed with people to promote healthy eating and a healthy lifestyle. For example, staff discussed with a person their favourite healthy foods, however they did not offer these as a healthy snack. Guidance was not in place for this person to maintain a healthy diet, and one staff member knowingly provided unhealthy snacks which put them at risk of harm. This was reported to the local authority safeguarding team.
- Staff told us due to COVID-19 people had to stop some of the physical activities they enjoyed, for example,

swimming. People were supported to have a walk, attend football once a week, however there were no other alternatives considered like on-line physical exercise classes or recommence the activities stopped after COVID-19 restrictions lifted.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support plans were not personalised, holistic, strengths-based and not reflected their needs and preferences. Staff had not involved people in reviewing their plans together. There was a lack of planning and implementing strategies to enhance people's independence.
● Whilst care plans were developed for most people for their current needs there was a lack of planning to develop and evaluate a pathway for future goals including skills teaching. For example, a person had an education care plan in place with the aim to develop their literacy and numeracy skills. Staff recorded every month that this person met their educational needs through the activities they were choosing. There was no meaningful plan to detail how this person was supported to achieve this goal, what aids were used and what progress they made. The provider told us from their knowledge of the person they would not choose to have such a plan in place.
● Staff had not received training and were not supporting people by using a positive behaviour support framework. The was a lack of planning and assessments in place to aid staff's knowledge about how to prevent people feeling anxious and being physically challenging. This meant that the support people received was reactive and not proactive in identifying triggers and signs of these behaviours and implementing strategies to prevent them.

The lack of personalised care plans and assessments in place was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● We found parts of the home in need of redecoration to maintain people's safety and to meet people's needs. For example, the bathroom had been found with black mould around the bathtub.
● People's bedrooms were personalised and decorated how they liked it.
● The provider told us they had plans to commence a maintenance programme to ensure the environment was improved and met people's needs.

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.

● Staff supported people in the least restrictive way. However, mental capacity assessments were not

reviewed, and best interest decision were solely taken by the registered manager without involving the person or others. This is not in line with the principles of The Act.

● Staff could not demonstrate how they empowered people's decision making by using appropriate aids and the MCA. Information was shared with people's relatives although the provider told us they did not know if relatives had the legal power for people's health and welfare. Independent Mental Capacity Advocates support for people was not considered.

● The provider told us they identified they had to develop staff's knowledge and their approach around MCA and best interest decision making to ensure they were providing people with appropriate support.

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

- People were not supported to have meaningful involvement in their care. They were not involved in setting and evaluating their goals and achievements to live fulfilling lives.
- Staff listened to people's day to day choices and they accommodated these as much as possible. However due to set staffing numbers each day in the home, there was little planning to support people to develop their individuality.
- People living in the home were mainly supported as part of a group and had limited opportunities to do things to develop their own individuality. The providers systems and processes were not developed to ensure staff could promote people's diverse needs and uniqueness. For example, when one person wanted to go to town, everyone else was encouraged to go. If one person liked to attend football, staff told us everyone else wanted to go as well.
- Whilst people's care plans listed the things they liked to do and they enjoyed, we found that these were not always part of the support they received. For example, a person liked swimming, however they were not supported to go swimming.
- People we spoke with told us staff were kind and friendly. One person said, "They [staff] are nice." We observed staff being warm, respectful and friendly towards people. They gave people attention and showed respect when talking to them.
- Relatives told us they were very happy about the support people received and found staff caring and kind towards people and often towards themselves.

Respecting and promoting people's privacy, dignity and independence

- People's support was not based around promoting independence. There was no guidance, care plans or discussions with people about gaining more independence in any aspects of their life. This limited people's progress to a more independent life in the future. For example, there were no plans to develop people's cooking skills, road awareness, voluntary or paid employment, achieving college degree or other acquiring other skills necessary for a more independent living in the future.
- Staff respected people's privacy and dignity. Each person had the privacy of their bedroom and staff were mindful to knock or wait for people to be ready for them to enter.

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 now deteriorated to required 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

- People were not receiving personalised care and support to meet their needs. Staff knew people well and they knew their likes and dislikes, however the support people received was not coordinated, consistent or planned for so that people could achieve positive outcomes.
- There was no evidence and staff could not easily come up with examples where people were supported to achieve goals, develop their knowledge and maintain and acquire new skills. One relative told us how pleased they were with the progress their family member had made in the short time they lived in the home. This was not evidenced in this person's care records. Staff told us the person's speech improved as well as they were happier.

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 no individual communication plans that detailed effective and preferred methods of communication, including the approach to use for different situations.
- We observed how people communicated with staff and found that staff understood people. However, there was no information available as to what people's preferences were when staff had to provide them with information.
- The provider showed us an easy read and pictorial system they were developing to aid people's understanding about subjects such as health intervention and social stories about different scenarios people could be faced with in the community. However, further consideration was required to ensure people had full access to all information about their care, in an accessible format.

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 supported to maintain existing relationships with their family members, however they had limited opportunities to develop new relationships. There was no information given to people or support for them to understand how to develop relationships which did not involve family members or staff.
- People had no information given to them to understand their sexuality, understand their needs and how to communicate their wishes and desires.
- Activities people attended included a social club facility run by the provider where people could meet with people living in other services run by the provider. There was no communication between staff supporting

people in the club and other staff in the service to understand and evaluate if people enjoyed these.
● Outside the set club activity days people had little choice as to what they could do. Staff told us there were less planning ahead and they just supported people on a daily basis going to town, café shops and the local park. Staff told us this was due to COVID-19 restrictions.
● One person enjoyed wrestling and staff supported them to watch this as well as weekly training with a football club. These activities were then offered to everyone in the home.
● People were not supported to have the desire to take positive risks and try activities outside their comfort zone. This limited their life experience and prevented them from developing new hobbies and interest.

The lack of meaningful engagement opportunities people had and lack of personalised support for people to develop new skills was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● End of life care and support for people had not been fully considered by the provider. Staff had not discussed this area of support with people or their relatives if appropriate.
● Staff had no training in understanding how to support people who were nearing the end of their life.

Improving care quality in response to complaints or concerns
● Relatives we spoke with told us they had no reason to complain as they were happy with the service.
● Staff told us people could raise any complaints or concerns they had with them daily or through meetings.
● When people or relatives raised any concerns there were no records of the follow up action taken and how things improved. For example, a relative of a person wrote to the registered manager to voice their concerns about the excessive weight gain the person had in the last few months, lack of activities and healthy diet. This had not been logged as a complaint and responded to in line with the providers complaints policy. No actions were taken by the registered manager and the person continued to gain weight.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager failed to take action to safeguard people from the risk of abuse, when staff or people reported concerns to them. The lack of their response and failing to report to local safeguarding authorities did not promote a positive culture in the service and exposed people to potential further abuse.
- We found evidence of a closed culture in operation. This was due to the lack of specific training, lack of reporting safeguarding incidents, poor application or understanding of the Mental Capacity Act (MCA) and Mental Health Act (MHA), including not following the MCA, DoLS and MHA Codes of Practice.
- People were not safeguarded against discrimination, harm and abuse. The registered manager had not led by example and failed to engage and respond to recommendations of external agencies and professionals. Records did not give a clear picture of incidents, triggers, or any analysis of learning to improve the service. Incidents were dealt with in the service not reported externally in an open and honest manner when things went wrong. For example, when a person reported concerns about a staff member or when staff raised concerns about another staff member's conduct.
- The lack of appropriate planning and risk assessing for people's support, the lack of training and mentoring for staff to understand current best practice when supporting people with a learning disability had a negative impact on people. For example, excessive weight gain, increase of medication to manage anxieties and lack of positive outcomes for people.
- The provider failed to implement an effective governance system to enable them to check the quality and safety of the service provided to people. The lack of meaningful audits and checks carried out by the registered manager and the provider had led to a service which operated as a closed culture, limiting people's opportunities and chances to live fulfilling lives.
- The provider and the registered manager failed to keep up to date with current requirements and best practice guidance. They failed in supporting people with a learning disability to live an ordinary life as any other citizen, guarantee people the choices, independence and support to achieve goals and positive outcomes.
- The registered manager and the provider failed to provide regular, good quality staff supervision and time for debriefs and reflective practice and challenge poor practice. Staff had not being given training to enable them to meet the needs of, and or effectively safeguard people living in the service. For example, training in

understanding autism or the care of people with a learning disability.

The lack of effective leadership, lack of governance systems and processes in place to ensure the safety of the service people received and the inability to identify improvements needed was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us, they identified prior to our inspection that they had areas they had to improve on, however our inspection highlighted to them how significant their failings were. They submitted an initial action plan for us to see how they were immediately actioning some of the concerns we found. However, the action plan had to be further developed to ensure it addressed the culture of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider told us they had not asked for feedback from staff or professionals involved in people's care in the last few years and this was because of COVID-19.
● People were asked for their feedback about the service in short surveys every couple of months and a more in-depth surveys was done once a year.

Working in partnership with others
● Staff involved health professionals in people's care and supported people to attend their appointments when necessary.
● Social care professionals visited people when needed, however the registered manager had not developed close working relationships with health and social care professionals to try and coordinate better support for people from the wider health and social care system. For example, involving learning disability specialists or positive behaviour specialists support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of staff to meet people's needs and unsafe recruitment process. The lack of suitably qualified, competent, skilled and experienced staff to meet people's needs put people at risk of not receiving care and support in line with best practice

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 There was a lack of personalised care plans and assessments in place. The lack of meaningful engagement opportunities people had and lack of personalised support for people to develop new skills was a breach of Regulation 9(person centred care)

The enforcement action we took:

NOP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safety concerns were not consistently identified or addressed. This placed people at risk of harm.

The enforcement action we took:

NOP positive conditions

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 Safeguarding concerns were either not identified or notified to the appropriate organisations. This placed people at risk of harm.

The enforcement action we took:

NOP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective leadership, lack of governance systems and processes in place to ensure the safety of the service people received.

The registered manager and the provider failed to identified failing in the service and improvement actions were not taken.

The enforcement action we took:

NOP positive conditions