Aston Care Limited

Hill View

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hill View is a residential care home that can support up to eight people. The service provides support to adults with a learning disability, dementia, mental health conditions and physical disabilities. The service consists of one two storey house and two self-contained annexes. At the time of our inspection there were 8 people using the service.

People's experience of using this service and what we found
Some people told us they felt safe. However, others raised concerns about their health needs not being met. During our inspection, we found that people were not always supported safely.

Risks to people were not always identified or managed effectively; including risks around medicines, environmental risks and choking risks. People did not have clear, up to date information in their care and support plans, meaning that staff could not effectively care for people. There was no clear oversight in the management of records, leaving people at risk of harm.

Staff were not always equipped with the necessary training and therefore did not always have the skills, knowledge and competence that is required to meet peoples' needs. There were not enough staff to meet peoples' needs in a way that promotes their well-being. People's safety was also compromised due to limited numbers of staffing at night. There was no effective system in place for staff to seek support out of hours.

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 best practice.

Relatives told us they were mostly happy with the care and support provided by staff. However, concerns were raised relating to lack of activities, complaints management, healthcare access for their relative, and communication.

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.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support:

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Information was not provided to people in different formats relevant to their communication preferences and people were not always supported to exercise their social interests. However, the building design fitted into the local residential area and relatives felt their loved ones were mostly treated with kindness.

Right Care:
People were not always supported with care that was person centred and promoted people's dignity, privacy and human rights. The service failed to ensure there were enough appropriately skilled staff to meet people's needs and keep them safe.

Right Culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services led confident, inclusive and empowered lives. The service failed to evaluate the quality of support provided to people or ensure risks of a closed culture were minimised.

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 16 August 2018). The service was also inspected on 30 December 2020 however was not rated at this time.

Why we inspected
The inspection was prompted in part due to concerns received about two other homes operated by the same registered provider. 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.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken some action to mitigate these risks, however, these were not always effective.
The overall rating for the service has changed from 'Good' to 'Inadequate' based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

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

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 the safety of people using the service, managing risks, the

leadership of the service, personalised care, consent for people, staffing levels and complaints.

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

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

We will 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

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.

Hill View

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by two inspectors, a specialist advisor and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Hill View 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. Hill View is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. However, there was an acting manager in post, who has applied to register with CQC.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 15 August 2022 and ended on 30 August 2022. We visited the service on 15 August 2022, 22 August 2022 and 30 August 2022.

What we did before the inspection
Prior to this inspection, we reviewed information we received from inspections of other services under the same provider. 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 also reviewed our monitoring processes such as information received about the service. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided and spent time with others observing interactions with staff, using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We continued to seek clarification from the provider to validate evidence found. We looked at training data, care plans and quality assurance records.

We spoke with seven members of staff and the manager. We spoke with five relatives and contacted three health and social care professionals about their experience of the service. We reviewed a range of records. This included four peoples' care records, daily records and medication records. We looked at four 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.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

● Staff had received some training. However, this was not always up to date and in line with people's needs. For example, we found that 14 out of 15 staff had medication training that had expired and that no staff had training in continence awareness.

● Policies were unclear around the use of physical restraint. The manager informed us staff had received training, however the training did not cover the forms of restraint that the provider's policy suggested should be used as a last resort.

●Where training in physical restraint was used, it was not recognised, and no attempts were made, to find less restrictive options to provide necessary care and treatment.

● Staff were able to explain the actions they would take if they had any safeguarding concerns. Staff explained; "I would contact my manager or would contact directly with safeguarding". However, during the inspection we found various safeguarding concerns that had not been identified. For example, peoples' health needs were not being followed correctly, leading people to be at risk of choking, pressure ulcers and poor epilepsy management. This culture allowed incidents of abuse to continue with little management or protection for people who used the service.

● There were no lessons learnt processes in place for incidents or accidents to be discussed with staff, or discussions with staff about improving the support people received. As a result, incidents and accidents re-occurred. For example, gaps in MAR charts were not identified or addressed, therefore, these occurred regularly.

Systems had not been established to assess, monitor and mitigate people from potential abuse. This placed people at risk of potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The service had very limited risk assessments in place for people that used the service, and these had not always been recently reviewed. This meant people were at significant risk of avoidable harm as staff did not have up to date information.

● We found people had risks in relation to choking, epilepsy, skin care and continence. Care records did not always contain up to date information on how to mitigate risks, or staff were not always following guidance to mitigate risks. For example, one person needed thickened fluid to reduce the risk of choking. We observed a staff member giving them a drink without thickener. When we observed this practice, the manager was unable to confirm if this person still required thickener. Following our observation, the manager later confirmed the person did require thickener. The practice of staff had put this person at significant risk of

choking.
● Another person was at risk of skin damage. We saw advice from a health professional was not being followed. There were no creams being used to reduce the risk of skin damage, no pressure relieving equipment being worn as per guidance, and no records in place to demonstrate repositioning.
● Where people had epilepsy, there were epilepsy protocols in place (instructions for how to recognise and respond when people had seizures). However, these documents had not been written by health professionals or reviewed, meaning that information relating to people's epilepsy may not have been accurate. Permanent staff were aware of people's seizure care plans, but staff told us agency staff were regularly used at night. During an out of hours visit, we found epilepsy monitors in use left unattended by staff for long periods of time. We also found records referring to possible unwitnessed seizures on various occasions. This meant that people were at risk of avoidable harm.

Systems had not been established to assess, monitor and mitigate risks to people ensuring their safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels within the service did not appear to meet people's funded hours and needs. The manager informed us there were three staff during the night from 7pm. During our out of hours visit, we observed some people were supported with baths or showers between the period of 3pm and 5pm. Others were in bed on our arrival. During this visit, we found one person, who required hoisting, was repeatedly requesting to get out of bed. We informed the staff about this, however, the person was not supported with this and remained in bed for the duration of the visit.
● One relative told us they were concerned that their family member often appeared to be in bed when they visited in the day. The person was unable to communicate whether they would like to go to bed throughout the day, and records did not indicate that this person liked being in bed. We were concerned there were not enough staff to ensure this person received personalised care to meet their needs.
● During our out of hours visit, we spoke with three staff. Staff told us they felt they needed an extra person throughout the night to sleep in, to assist in the event of an emergency. Another staff member told us, "It is really hard when there are just two staff here." We reviewed rotas for support provided throughout the night and found that, on many occasions, there were two night staff supporting eight people, two whom required 1:1 support at all times. We raised this with the provider following our inspection, and they assured us that they would review the rota to ensure there were three staff on every night shift going forward.
● During our inspection, we observed that epilepsy monitors and people who required supervision were left unsupervised, placing people were at risk of significant harm
● We found people's needs could not always be met due to lack of staffing. During our inspection, we observed two people requesting to go out periodically throughout the day. One person was briefly supported with this, however the other was not. We raised this with the provider, who informed us that the service is actively recruiting staff.
● Agency staff profiles were not in place during our inspection. The manager told us no new agency staff had been used and therefore they had no recent profiles of staff, or any evidence of induction. However, we observed a new agency staff working during our inspection. The member of staff confirmed they had not received any induction prior to supporting people. Therefore, we were concerned their suitability was not checked by the service prior to work.
●The manager did not have a clear oversight of staffing levels within the service. The manager had no awareness of peoples' funded hours and therefore these did not always appear to be provided.

We were not assured enough suitable staff were deployed to meet people's needs safely. This was a breach

of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People were at risk because the provider did not manage medicines safely.
● The provider was not always clear about their responsibilities and role in relation to medicines.
● The provider did not always follow relevant national guidelines around storing and disposal of medicines. For example, we found that medicines were stored in cupboards that exceeded the recommended temperatures on 27 occasions in the month of July, however no action was taken as a result of this. Medication audits did not pick this up; this meant that systems were not effective in identifying problems, placing people at risk of harm.
● The provider did not always follow relevant national guidelines in relation to non-prescribed medicines that it managed for people.
● The provider did not follow correct procedures when people lacked capacity to make decisions about taking medicines and when they may need it to be administered without their knowledge or consent.
● People did not always receive their medicines as prescribed. During our inspection, we observed various gaps in medication administration records. We addressed this with the manager, however they could not explain the reason for these.

Medicines were not managed safely. This was a breach of regulation 12(1) This was a breach of regulation 12(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider did not have any general or specific environmental risk assessments in place, despite guidance from HSE which states that; 'Health and social care providers should carry out a full risk assessment of their hot and cold water systems and ensure adequate measures are in place to control the risks.' We found people were using a hot tub regularly, however, no health and safety checks were in place for this and no risk assessment completed. This was a breach of their policy around Legionella. During our inspection, we found that the water in the hot tub was unclear and contained flies. This placed people using the hot tub at risk of contracting Legionella disease.

Failure to have appropriate systems in place to ensure the safety and well-being of people 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.

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection, responding effectively to risks and signs of infection, and promoting safety through the layout and hygiene practices of the premises. For example, during our out of hours visit, we observed that people who required support with continence care, did not always have clinical waste bins in their bedrooms. We also found used continence products in uncovered waste bins.
● We were not assured that the provider's infection prevention and control policy was up to date. This was out of date at the time of inspection.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. For example, the service appeared clean and tidy.
● We were assured that the provider was preventing visitors from catching and spreading infections. For example, we observed an area where safe visiting could take place during COVID.

We have also signposted the provider to resources to develop their approach

Visiting in care homes

● We were assured the provider was facilitating visits for people living in the service in accordance with the current guidance. The staff at the service carried out checks and recorded information according to visiting rules before the inspectors could enter the premises.

Learning lessons when things go wrong

● The provider did not have an effective system to review and investigate where concerns were raised. The provider recently had two of their other services inspected, where similar concerns were found. There was no evidence any of the learning from the other inspections had been shared across the provider's services. This meant people were at potential risk because the necessary improvements had not been identified and plans put in place to act where needed.

● Actions were not taken as a result of accidents and incidents. This meant that lessons could not be learned in relation to preventing accidents and incidents from re-occurring.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Care and support was not based on full assessments of people's needs. Expected outcomes for people had not been identified and care and support plans were not regularly reviewed and updated.
- Care and support was not planned and delivered in line with current evidence-based guidance, standards, best practice, legislation. For example, epilepsy protocols were not written and reviewed in line with the NICE guidelines.

Staff support: induction, training, skills and experience

- Staff were not adequately trained and therefore did not always have the skills, knowledge and competence that is required. For example, we found all staff had either expired, or no training in safeguarding or moving people safely.
- The provider had not ensured staff had training that was in line with best practice or kept up to date. Training and development plans were not designed around learning needs and the care and support needs of people who used the service. For example, we observed two people were at risk of, or had pressure sores. However, there was no training available for this, and we observed that staff did not always act proactively in relation to pressure care.
- We found staff supervision and support was not always consistent. Some staff told us they felt supported by management; "Personally I do feel supported by (manager)", however others told us, "We are asked to update care plans and we don't feel trained to do this," and "(manager) comes in at 9.30/10 and then leaves early, even when there's stuff still to be done."

The service did not always ensure enough suitably qualified, competent, skilled and experienced staff were deployed to support people. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough 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

- Records around people's eating and drinking were not always consistent and did not always meet people's needs. For example, we observed that one person had lost a lot of weight in a short period of time. This person was not being monitored in line with MUST guidelines, placing this person at risk of malnutrition.
- The service monitors people's health, care and support needs, but does not consistently act on issues

identified. For example, we found various references to unwitnessed seizures in people's care records. However, no action was taken as a result of this meaning people were at risk of not receiving their rescue medications as prescribed.
●We saw evidence that some people had been supported to attend some health appointments. However, one family member raised a concern that a person had not been supported to access the dentist for many years. The family member had raised this with the staff and manager; however, there was no evidence that any action had been taken in response to this.
●During our inspection, a person at the service raised a concern with us relating to their own health concerns and lack of support around booking appointments. The person had raised this with staff and disclosed that no action had been taken. The person stated this led them to feel depressed. We raised this with the manager, who stated this person manages their own health needs. However, the person we spoke with said they needed support with this. It was unclear in the person's care records who managed their appointments.

The service did not effectively monitor and respond to peoples' health needs. This was a breach of Regulation 9 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 needed repair to maintain people's safety and to meet people's needs. For example, two bathrooms needed repair, and one person's window was broken throughout the course of the inspection. Staff also raised concerns relating to this. When asked whose responsibility this was, staff told us "no-one is solely responsible."

The service was not always well maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that some people's bedrooms were personalised. For example, one person liked buses. The person had pictures of buses on their bedroom walls.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●We found limited and inconsistent records in relation to Mental Capacity Assessments and Deprivation of

Liberty Safeguards. For example, most people had MCA's around consent to having the second COVID vaccination, however there were no observed MCA's completed around consent to care and treatment, locked doors, window restrictors, continuous supervision and bed rails.

- We found one person had a DOLS authorization in place with conditions that had not been met.
- We observed staff were not always working within the principles of the MCA. The provider did not ensure that people's capacity to make decisions was assessed when needed. For example, we observed that PRN protocols for medications such as paracetamol, were not in place for those who lacked capacity. We raised this with the manager, who told us, "We wouldn't necessarily give paracetamol as they don't have capacity, so couldn't tell if they needed it." During our inspection, we observed some people appeared to be in pain. Staff also raised concerns regarding this. This meant people were at risk of experiencing pain unnecessarily.

The service did not always work within the principles of the Mental Capacity Act 2005. This was a breach or Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people 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 always involved in decisions relating to their care. For example, people did not have regular reviews relating to their care and treatment. The manager told us this was because people's needs had not changed.
- We observed people were not always treated within the principles of equality and diversity. For example, community access was limited. However, where people did access the community, this was not always person centred as people were mainly supported as part of a group. Therefore, people had limited opportunities to do things to develop their own individuality.
- We observed some people were offered choices of what to have for lunch. However, we also observed people requesting to go out on three occasions, and this being dismissed.
- People were not involved in setting and evaluating their goals and aspirations to live fulfilling lives.
- 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, we observed one person's care plan stated that it is important for them to access the community every day. However, activity audits showed that this was not always the case and that community access was limited.

The service failed to consistently involve people and their representatives in decisions about their care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed that staff spoke with people kindly, and people appeared to respond positively to staff.

Respecting and promoting people's privacy, dignity and independence

- We observed people were not always treated with dignity and respect. For example, we observed one person being fed their lunch time meal. However, this person's care plan states they can feed themself. The person's family member had also raised concerns about this.
- 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.
- We saw no evidence to demonstrate people had a choice of when they wanted to get up or go to bed. We observed that some people were supported with evening personal care routines between the hours of 3pm and 5pm, and that many others were in bed at 7pm. Many of these people could not express when they wanted to go to bed.

The service failed to promote people's dignity and independence. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires improvement. This meant people's needs were not always met.

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

- Care was not personalised and in line with the Right Support, Right Care, Right Culture guidance. The service had not always supported people to follow their individual interests or encourage them to take part in social activities relevant to their interests or hobbies.
- People did not appear to have much choice and control over their lives. For example, we observed that people were not involved in meal planning.
- There was no evidence that people's views had been sought in relation to their own care. For example, we observed some key worker monthly reports, however these were inconsistently completed and had not been completed with people.
- People's care needs were not regularly reviewed. Their care plans were out of date and did not sufficiently guide staff on their current care, treatment and support needs.

The service did not provide people with personalised support to meet their needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The service has not fully implemented the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.
- Staff did not always have training to meet people's communication needs. For example, we observed that one person used Makaton. There was no evidence that any training for this communication system had been sought for staff and we observed staff communicating with people verbally. This put the person at risk of not having their needs met.
- People did not have specific care plans around communication. Information relating to communication was limited.
- Alternative communication systems had not been explored for those that could not communicate verbally, such as Picture Exchange Communication Systems (PECS).

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

●We observed that some people were supported to follow interests and to take part in activities that they enjoyed, however others were not.

● The service did not always enable people to carry out person-centred activities and encourage them to maintain hobbies and interests. Reasonable adjustments were not always made (such as suitable staffing levels to enable activities to take place) to remove barriers so that people could access activities they enjoyed.

●The manager told us that visiting during COVID was enabled in a specific area of the service. We observed this during our inspection.

● Feedback from relatives around activities and community access was mostly negative. Comments included; "I wish they would do more - there is not enough stimulation for (relative) at the home".

Improving care quality in response to complaints or concerns

●Complaints and concerns were not always acted upon and responded to in line with their own policy.

● The manager told us they had not received any complaints. However, we heard from a person's relative that they had raised concerns on several occasions relating to their family member being left in bed, lack of dental care sought, and lack of support provided. During our inspection, we found no evidence that these concerns had been addressed.

●There was no procedure in place for people using the service to raise concerns. For example, there was no easy read document in place.

The service had not responded to complaints effectively and in line with their own policy. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● End of life care and support for people had not been fully considered by the provider. Not all people had records in place or any evidence that staff had discussed this area of support with people or their relatives, where appropriate.

● All relatives we spoke to confirmed that this aspect had not been discussed. Comments included; "No discussion has taken place concerning an end of life care plan".

● Staff had no training in understanding how to support people who were nearing the end of their life.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, 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 service was not well-led. There had been no registered manager for some time and governance and performance management was not always reliable and effective.
●Systems and policies were not regularly reviewed, and risks were not always identified or managed.
● The manager did not seem to be fully aware of or understand their responsibilities in relation to ensuring the service was safe and of high quality. As a result, the provider and manager failed to keep people safe from known risks.
● There was a lack of meaningful audits and checks carried out by the manager and the provider, leading to a service which put people at significant risk of harm and a decreased quality of life. For example, activity audits were not effective in identifying that a person had not accessed the community as per the preferences detailed in their care plan.
● The provider and 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.
●We found no evidence that the provider understands and acts on the duty of candour. For example, concerns had not been responded to appropriately.

Governance systems failed to assess, monitor and mitigate the risks to people or maintain securely accurate or up-to-date records of people's care or the management of the service. This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a lack of specific training available for staff.
● Legislation such as the MCA, DoLS and MHA Codes of Practice were not always followed and adhered to.
● The lack of appropriate planning and risk assessing for people's support, and 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, we observed that staff were not always supporting people in the least restrictive way.
● The manager and provider had failed to provide regular, good quality training to enable them to meet the

needs of, and effectively safeguard people living in the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care

- People were not involved in decisions relating to their care.
- Relative's views were not always sought to improve the service, such as using surveys. Relatives told us "No we did not receive questionnaires".
- Records did not give a clear picture of incidents, triggers, or any analysis of learning to improve the service.

Working in partnership with others

- We observed that some referrals had been made to external agencies. For example, one person was referred to Speech and Language Therapists (SALT) and had guidance from this service in their file. However, this guidance was not being followed by staff and people were unaware of this.
- Relatives were not always involved in the review of care and support plans. Relatives' told us; "No I have not been involved with any review or seen a care plan", and, "I have not seen a care plan, but I have been to reviews. The last one was a while ago though".

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 that appropriate referrals have now been made. For example, that a referral was put in for an Occupational Therapist in relation to the pressure care of one person, and that contact was made to clarify information relating to guidance from the speech and language therapist.

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 9 HSCA RA Regulations 2014 Person-centred care The service failed to consistently involve people and their representatives in decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always work within the principles of the Mental Capacity Act 2005.

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 had not been established to assess, monitor and mitigate people from potential abuse. This placed people at risk of potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service was not always well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

The service had not responded to complaints effectively and in line with their own policy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We were not assured enough suitable staff were deployed to meet people's needs safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service did not ensure that people were safe.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure appropriate governance systems were in place.

The enforcement action we took:

Warning notice issued