Home Group Limited

Nicholas House

Inspection report

Nicholas House
Cairns Close
St. Albans
AL4 0EY

Website: www.homegroup.org.uk

Date of inspection visit:
26 April 2023
03 May 2023

Date of publication:
15 August 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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
Nicholas House is a supported living service providing personal care to up to eight people. The service provides support to people with a learning disability and autism. At the time of our inspection there were three people using the service.

Nicholas House is one building with eight flats. Within the building there is an office for management and staff. All people who used the service at that time received personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

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

Right Support: Model of Care and setting that maximises people's choice, control and independence.
Staff did not always support people with their medicines in a safe manner. There continued to be a lack of robust systems in place to manage medicines, however the provider took some action to remedy this.
People were not supported to have maximum choice and control of their lives. This was because systems to support and deliver care were not utilised consistently at a local level around staff deployment and staff training. Most people were not supported to make decisions, engage in activities or access the local community.
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 required were in place but not effectively implemented within the service to support this practice.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights
People had care plans and risk assessments in place; however, these were not always up to date or shared with the staff who needed to be aware of them. Staff were seen to not communicate effectively with people. Additional communication tools to support effective communication had not been put in place. Care did not always promote people's dignity. People had for periods been without the required staff support which had placed them at risk and caused anxiety and distress. Most staff approaches were well intended and well meaning, but without sufficient support, staff did not understand how to assist people in the way that would best support their care and wellbeing. Staff training and supervision was not up to date and did not support staff effectively. The service worked with other agencies but professionals told us there were barriers to reviewing support needs. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives
The ethos and values of the provider were not embedded in care delivery. Management of the service was not robust. Staff felt unsupported by management and the provider. Oversight of the quality and safety of the service did not ensure actions to improve the quality of support were completed. Records relating to people's care required review and updating to ensure they were fully reflective of people's support needs. People were not supported by staff who understood best practice in relation to supporting people with a learning disability. People were not always able to exercise choice and live an ordinary life as other people. Relatives were not actively involved in decisions about the service they received. The behaviour of managers did not support people's involvement in care and help them to express their views and feelings.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 September 2022). At that inspection we found the provider was in breach of regulations relating to safe care, staffing and governance. At this inspection we found the provider continued to be in breach of those regulations. We also found further breaches in relation to consent, dignity and respect, nutrition and safe care and treatment. The service is now inadequate.

Why we inspected.
This inspection was prompted by a review of the information we held about this service.

The inspection was also prompted in part due to concerns received from the local authority about safeguarding concerns, safe care, staffing and management of the service. 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 our 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 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. The provider had begun to take action to address immediate concerns but worked with the local authority to transfer care to another provider.

You can see what action we have asked the provider to take at the end of this full report. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nicholas House 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 consent, staff training, medicines management, infection control, person centred care and overall management 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 work with 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?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Nicholas House

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 2 inspectors (one of whom specialised in learning disabilities).

Service and service type
Nicholas House is a supported living service. It provides personal care to people living in their own house. The service provides care and support to people living in one 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post although they were absent at the time of our inspection.

Notice of inspection

This inspection was unannounced.

What we did before the 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 reviewed support plans and associated records for 3 people. We reviewed medicines administration and associated records for 3 people and spoke with 6 members of staff. We spoke with 3 relatives and 2 people who lived at the service and observed staff supporting 3 people. We spoke with a Registered Manager from another service supporting Nicholas House, a Deputy manager, the Operations Manager and the Head of Care.

After the inspection we received further documentation electronically, such as governance audits, recruitment files, supervisions, and minutes of meetings. We continued to liaise with the local authority about our concerns following the inspection.

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 Requires improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our previous inspection people were not supported to manage risk and medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider continued to remain in breach of this regulation.

Using medicines safely

● Staff had received training to manage and administer medicines. Staff had been assessed as competent to manage these safely. However, the provider carried out competency assessments on the first day of our inspection for all staff following concerns raised to them by the local authority. This was carried out over two days and most staff failed to assure the provider they were safe to administer and manage medicines.

● People did not receive their medicines as the prescriber intended. For example, one person's medicine was reviewed by their GP in 2021 where it was changed from a daily medicine to a PRN (As required). This was updated in the records meaning there had been occasions where staff continued to administer daily against the prescriber's instructions.

● One person was prescribed medicine to aid their constipation as a regular daily medicine. Staff did not administer this regularly as prescribed and gave on only one occasion as a PRN (as required basis). This resulted in this person becoming constipated. We found a second person had medicines administered as a daily medicine when it should have been given on an as required basis.

● PRN protocols were not always in place to instruct staff when and how to administer as required medicines. Staff did not monitor people routinely for signs and symptoms of the condition they were administering the medicine for. Without the appropriate protocol in place this meant staff were not clear on when to administer as required medicines or how to monitor people.

● People were prescribed medicines to alleviate their distress or anxiety as a PRN. A risk assessment and care plan were in place to instruct staff what actions to take before administering medicines to control mood or behaviour. However, we saw from the records that staff routinely did not try any distraction or intervention and immediately resorted to using medicines as a means of controlling behaviour. This meant people were at risk of being restrained using medicines.

● Body maps were not in use for recording the application of people's topical medicines such as creams and emollients. We found that some information about people's medicines available to staff was inconsistently recorded and potentially misleading. This included information about people's allergies and medicine sensitivities.

● We were not able to confirm that people living at the service received regular reviews of their medicines by prescribers in line with national guidance. Audits completed by the management team prior to the

inspection did not identify the issues found at this inspection.

People's medicines were not safely managed or administered in line with the prescriber's intentions. Staff were not competent to manage or administer these medicines and leadership did not identify the improvements needed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People and relatives gave mixed feedback on the support they received. One relative told us, "It's a good team at the minute. They have only recently changed the care plan, but the support given is safe." We spoke with one person who signed to us they were sad and did not want to stay in Nicholas House. Their relative said, "Nicholas House did not provide safe care. As a family we saw the signs of failures on their part and highlighted to them that [Person] was deteriorating. They kept saying that we should give them time to settle down. Now 8 months to nearly 9 months on, they have not managed to get [Person] settled and not provided him safe care."
- Positive Behaviour Support (PBS) plans were in place for people. These plans aim to enhance quality of life as both an intervention and outcome for people. Although these plans were in place, not all staff had access to them, and we found numerous examples where staff did not follow these.
- One person had left the service due to their increasing support needs. Staff told us they felt they did not have the skills to keep them safe from harm. One staff member said, "If we had all of the right staff, training and support plans I think this would prevent them going into hospital if we could support them properly, we were failing."
- One person had been referred to a consultant psychiatrist for a review of their medicines, with staff requesting an increase to manage mood. This was not granted, and staff were told to increase activity and engagement. This did not happen, which resulted in increased aggression and agitation towards staff.
- When we observed staff, they did not seem to be confident when supporting one person, and both were using different way of communication towards the person. Staff told us they were not confident in supporting people when they became distressed or agitated. We saw further examples where staff interactions caused people distress. For example, staff arguing with a person resulting in them becoming aggressive and destroying property. A second example, where staff did not plan an activity safely, taking a person to a busy shopping centre resulting in them becoming overwhelmed and placing themselves in a dangerous situation.
- Some risk assessments and care plans were not in place to guide staff in areas such as constipation and epilepsy. One relative told us, "[Person] has epilepsy and has absences that are hard to spot, they can be missed if you don't look. I have not seen anything written down for his seizures." This placed people at risk of harm as some health needs had not been fully assessed and staff were not aware of how to monitor.
- Regular audits such as health and safety, environment and cleanliness were completed, however these were not effective in improving issues identified. For example, a few maintenance issues had been raised and not resolved in a timely way. We found a fire safety assessment had been completed which raised no significant issues.
- The cleanliness of people's flats and the communal areas was variable. We saw one person's flat which was not clean. The person's family had organised for the person to return home whilst staff undertook a deep clean. This was not completed, and the person return to a flat that was not clean. This posed a risk in relation to managing and minimising the risk of infection. Parts of the communal areas which people could access were dirty and prompts by CQC on the first day of the inspection to the management team were given to clean the building.
- Staff were not wearing PPE (personal protective equipment). There was no indication in the care plans that they have spoken to people to gain their thoughts about PPE and their preferences.

● We found the environment to be poorly maintained and standards of hygiene in some areas were not adequate. Failure to ensure the environment is clean, hygienic, and safe, puts people at risk of harm and infection.
● Most staff had received infection prevention and control training however staff practice posed a risk in relation to managing and minimising the risk of infection.

Care and support was not provided in a safe way for people. People did not live in a clean environment that protected them from the risks of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Two relatives told us they did not feel safe care and support was provided. Relatives did not feel all staff had the skills and knowledge to keep people safe from harm. One relative said, "They don't fully understand. The caring staff don't understand the training and welfare and don't fully understand the role."
● One person was subject to restrictive practices without the proper legal authority to do so, which included restricting them to their own flat. Safeguarding referrals to the local authority in relation to this practice were made.
● We saw incidents that had not been reported to the local authority safeguarding team where people were at risk of harm.
● Staff did not routinely discuss or reflect on incidents through meeting or 1:1 debriefs [Known as brilliant conversations]. We could not be assured that staff were knowledgeable about how to identify and report potential abuse. Staff had completed training in safeguarding and protection of adults however they had no checks of their competency carried out.
● On 18 May 2023 a meeting was held with the provider, local authority and CQC. The provider reported they could not keep people safe in Nicholas House. A protection and support plan for all people was agreed while the local authority supported with the commissioning for a new provider to undertake support. The provider told the meeting the level of leadership and support required to ensure the level of improvement needed was unsustainable.

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.

Staffing and recruitment
● The provider had not ensured that sufficiently skilled staff were employed to ensure they could safely meet people's support needs. The operations manager told us about recent recruitment, "We have had a lot of recruitment going on and haven't always recruited well, we recruited staff that maybe we wouldn't have done. A lot of staff without the experience of this group." One relative told us, "There is no consistent staff, and they don't know how to talk to [Person]. It is sad to see [Person] doesn't get the same life they had at home."
● The provider, relatives and the management team told us people required a consistent, confident, experienced staff team. We saw several examples where this was not provided. For example, during our inspection we observed one person who required two staff to always support them. During a ten-minute period, we saw six different staff support them, each with a differing approach that caused this person further anxiety. We also observed one staff member leave this person with only one staff member, which was not in line with their assessed support needs. One relative said, "The well-trained staff who knows [person name] are constantly leaving the job leaving [Person] with new unfamiliar faces causing a lot of anxiety and distress triggering their behaviour to escalate a lot of times."
● Staff told us that they did not always have enough staff to drive people in the community, they would

frequently use staff from different teams, some of whom did not know people well.

People were not supported by a consistent staff team. The staffing structure did not support the delivery of person-centred care to people to support their independence and keep them safe from harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited following the providers policy which included background checks such as employment references and a criminal records check.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support, and outcomes.

At our last inspection we found the provider failed to ensure staff were adequately trained. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had not been made and the provider remained in breach of this regulation.

Staff support: induction, training, skills, and experience

- Relatives told us staff skills and experience had changed with a few team leaders and support workers leaving. Staff told us these vacant positions were not replaced with staff who were sufficiently skilled. Current staff told us they did not feel they were confident or competent in supporting people in Nicholas House. One staff member said, "Some staff are new to care, the people that worked best was the experienced staff. Getting the right staff in is important, the service ran before they could walk with very complex care needs." A second staff member told us, "We are not doing the right thing."
- Two people's relatives said staff did not understand people's support needs and felt staff were not trained enough to support them. One said, "The well-trained staff who knows [Person] are constantly leaving the job, leaving [Person] with new unfamiliar faces causing a lot of anxiety and distress triggering behaviour to escalate a lot of times."(Quote used in safe) The experiences of staff and relatives demonstrated that people were placed at risk by staff who had not been sufficiently inducted to their role, trained or offered adequate support. The interim manager said, "All training is identical with in all the services in Home Group. E-learning is bespoke and good training, so I think it has failed somewhere in Nicholas House that the processes just have not been followed."
- The training record we were shown demonstrated not all staff had attended training relevant to their role. 39 staff were on the training record, of these 18 staff had not completed Person Centred Care. 12 staff had not completed ProAct Scip [PROACT-SCIPr-UK® consists of positive approaches to behaviour management, which encourage the use of proactive responses.] 10 staff had not completed training for learning disabilities or autism. 16 staff had missed record keeping. 4 staff had not completed nutrition training. No staff had completed training for those who may self-harm, first aid or Makaton. The registered manager had not completed required training in practice leadership, medication, risk management, root cause analysis, mental capacity, person centred care, Makaton or working with customers who self-harm.
- Staff had not received appropriate supervision for them to discuss their training and development. Although staff were supportive of the registered manager, they had not had the opportunity to be supported through meaningful discussions about their role.

The registered manager had not carried out any assessments of staff competence. People were placed at risk by staff who had not been sufficiently trained or offered adequate support. This was a continued breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● A 'FACE' risk profile was completed for each person using the service. These were available to staff using the electronic system. Risk assessments were then developed from the initial 'FACE' assessment. Some of the risk assessments required updating around some areas of risk, such as continence, epilepsy and positive behaviour support management.
● Staff held a paper record in the persons flat, but these did not correlate with the electronic assessments. This meant that staff supporting people in their flats had limited information from the support plans to ensure they had up to date information. This meant staff were not informed of how to provide support, particularly around behaviours that challenge and therefore did not have the information to keep people safe.
● Although PBS plans were detailed, recording people's preferences, choices and support needs, staff did not follow these, meaning people were placed at risk. We saw examples where staff did not follow the measures needed to help people feel safe when outside of their home environment. Staff did not follow these resulting in people putting themselves at risk of harm.
● People's support needs were reviewed through MDT meetings. However, these were held infrequently. This meant the systems in place to assess, monitor and review people's safety and welfare were not in place meet people's changing needs.

Although people's needs were assessed, their physical, mental health and social needs were not supported in line with legislation, standards and evidence-based guidance. This was a breach of regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● Staff, and the interim management team were aware of their responsibilities in relation to the MCA. We looked where MCAs and best interests decisions were required and found some decisions, such as covert administration of medicine did not have an MCA in place. The best interests decision had been completed by the prescribing GP, but did not consider least restrictive options, and lacked detail around the rationale.
● We saw examples of applications that had been made to the Court of Protection as required. However, we also found examples where the registered manager had failed to identify where people were being potentially unlawfully restricted. For example, with being restricted to their flat. One relative confirmed this had been an ongoing concern. They said, "[Person] is locked up inside the flat with 2 or 3 support workers gowned up with gloves controlling [Person] in the flat. Sometimes, some of the staff who are not familiar

with them will leave [Person] isolated alone in the bedroom whilst they [staff] will lock themselves away in the kitchen sitting in chairs with their feet up and on their phones."

Systems were in place but not effectively implemented to ensure care and treatment of service users was only provided with the consent of the relevant person. Where people were restricted in the daily living, the appropriate applications had not been made. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives gave mixed views about the support given to people with their eating and drinking. One relative told us they were involved, brought in regular shopping and snacks, and staff adhered to the menu plans agreed. However, a second relative said, "They [managers] promised to support [Person] with activities care plans, meal plans which they said they would share with us, that has never happened for nearly 9 months."

● We observed that not all people were always supported to eat and drink enough to maintain a healthy balanced diet. For example, one person was eating a microwave sausage and mash potato for dinner. The only other food in their flat was 5 apples and a container of half empty chicken wings and sauce in the fridge. There was no menu planning in place that took account of this person's dietary needs, preferences, or choices. Snacks and drinks were not available to meet their preferences.

● We were unable to establish from care records whether people's weights were monitored by staff to determine the risks to people.

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

● Staff liaised with relevant healthcare professionals where required. However, feedback from professionals was that information sharing was at times difficult with delays, barriers, or a lack of knowledge. They said, "Staff feel they can't challenge the management or go against management decisions. It's frustrating on our end. They do not get the difference between daily living or care tasks, daily activities, outings and meaning activities."

● Where people had been assessed by healthcare professionals the registered manager had not always ensured this guidance was available for staff to follow. This is because this information was not made available to staff supporting people who did not have access to the electronic records.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. 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; Respecting and promoting people's privacy, dignity and independence.

- The provider and management team had not ensured people received care that reflected their diverse needs or was dignified. People's choices, needs and preferences had been documented but were not always followed. Care plans contained information about what people could do for themselves and how to promote independence around mobility for example. However, care was not always being delivered in line with the care plans and independence was not always promoted.
- People's privacy and dignity were not always respected. We saw for example staff had neatly folded a blanket and placed in on a person's bed ready to use. We saw this was stained and when challenged the staff member confirmed this was old faecal stains that could not be removed. We observed staff walking into a person's flat without knocking to collect their belongings before going home. This staff member was not part of the team allocated to this person.
- People were not all well treated and supported. One relative told us, "Usually, when I am there, they are not engaging with [Person], staff sit in the lounge or kitchen having an argument and could be heard from [Person's] room. The staff are unprofessional. As I left the service the other day, I could still hear the staff arguing."
- We saw a staff member shouting at the door to another person whilst getting ready to go out rather than going to speak with them in privacy.
- Observations showed some staff supported people with positive interactions however, other staff were seen to be not talking to people when supporting them. One relative said, "Sometimes, some of the staff who are not familiar with him will leave him isolated alone in his bedroom whilst they will lock themselves away in [person name] kitchen sitting in chairs with their feet up and on their phones. This I have noticed during my unannounced visits."
- The language used by staff was not always appropriate. For example, when one person was agitated, staff were heard to say, "Come on [Person] you are a good boy." We repeatedly heard and saw examples where staff used terms that were not dignified or appropriate when addressing young adults.
- The provider and management team did not demonstrate a caring approach to people or the staff supporting them. Staff were well intentioned and wanted to provide good care, but the provider had failed to embed good practice within the service. The audits and oversight from the provider were not effective in ensuring people received care that met their needs. Although the provider did take action to make some improvements during this inspection, they failed to address the issues above and terminated the packages of care.

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

●People were not all consistently supported to express their views or be involved in decision making about their care. One relative told us, "Only review we had was from social services by [person's name] amazing social worker who goes above and beyond." The PBS plans and care records did not evidence where the views of people were sought or their relatives. One relative said they were more involved but that they had to approach staff with instructions as opposed to a review.

People's care was not provided in a way that supported people's independence, choice, reflected their views and respected their dignity and privacy. This was a breach of regulation 10 dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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

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

- People's care was not always well planned and did not fully meet their needs. 2 of the 3 people's preferences about how they spent their day were not met, and people were not free to have choice and control around how they met their own preferences.
- People were rarely supported to engage in meaningful activities. 1 person did attend social clubs, had plans in place for day trips and had done some gardening. They were able to decide how they spent their day and their staff team encouraged them to pursue interests.
- For the other 2 people this did not occur. We saw for 1 person their personal plan updated in February 2023 to, "Identify and draft a risk assessment for at least 1 community activity." None had been completed and this person did not go out of the building for any meaningful activity until this inspection. Their relative told us, "The psychiatrist told us and the [registered manager] clearly that [Persons] behaviours had been triggered by lack of engagement and a lack of activities. They advised the registeredmanager to get the staff to engage with activities like taking them to open parks to walk and exercise because he is full of energy. This did not happen, and incidences of aggression continued to occur." We saw that a bicycle had been left to rust in the garden. It was noted in the PBS plan that this person enjoyed cycling, but staff had not sought to organise this.
- A second relative said, "The times I go [Person] is sitting in their room, they never go out in the car, but when I go, they like to go out in the car with me." They went on to further say, "Meeting [persons] needs are adequate and social interaction is not much. [Person] likes talking they will try to start a conversation and expect staff to know what they need, but this is not done. The staff should know what he needs. Mum has made a book with the language used around those topics. The staff should know how to have that conversation. When I am there, I do not see this happening, I see the bare minimum each time such as a having drinks and food."
- People's families were welcomed, and staff promoted regular visits from relatives. However, people were not encouraged to develop new relationships, either within Nicholas House or through external groups, trips, friendship groups etc. Staff did not always explore how they could support people to learn new skills to develop their independence and choice.

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.

● People's care plans reflected their individual communication needs but staff we spoke with did not fully understand people's methods of communication. People were not all able to communicate well with staff and as a result were not always understood by them.
● We observed 1 person with staff who did seek to hold an active conversation with them. Staff merely responded to people's needs or requests and did not engage in discussions. 1 person communicates with staff through writing on the wall. However, this person understands Makaton. Makaton is a communication method that uses symbols, signs, and speech to enable people to communicate. When meeting the person, we were able to have a conversation through sign and writing. This person was able to understand us and reply. They told us they were not happy, wanted a bath and wanted to go home. When speaking with staff they said they did not have the training for this. Staff therefore were not fully able to communicate with people, or support people emotionally when they felt sad, anxious, or lonely.
● 1 relative said, "All they [staff] do is write on wall. This was the only communication method adopted by staff. No other appropriate communication methods were initiated to help [Person] interact. [Person] is isolated most times as staff were not engaging them with activities." This relative went on to say that as they could not always express their desires, wants or feelings to staff, this led to outbursts of anger, which if staff could understand, would likely reduce the frequency of those.

Not all people were supported to make choices to have appropriate control of their daily care to meet their preferences. People were not always supported to engage in activities they wished to enjoy or be part of the community. People were not always able to communicate or express themselves appropriately. This was a breach of regulation 9 person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Relatives gave mixed feedback to us about the registered managers response when they raised concerns. 1 relative said they were responsive and took steps to address those issues. However, other relatives told us the response was variable. 1 relative said, "The care manager sometimes emails us after we complain. There was no responsible senior leadership to contact, apart from the support staff in the flat whenever we wanted someone to talk to. Sometimes when the support staff caring for [Person] gave us a duty manager's number to call, we do that and get no response or call back."
● We looked at the complaints received over the previous 12 months and could see these when reported, were reviewed and responded to. Where necessary, senior managers would respond and investigate. However, our discussions with relatives showed that not all the complaints they raised had been documented, meaning they did not receive a response. This also meant the provider did not have an accurate reflection of the levels of satisfaction within the service as an indicator of poor care or management.
● The provider had a complaints policy in place and copies of the policy were provided to people and their relatives.

End of life care and support
● At the time of the inspection nobody was receiving end of life care. Further improvements were required to ensure people's end of life wishes were robustly recorded to reflect their preferences.

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 requires improvement. At this inspection this key question 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.

At our previous inspection we found the culture of the service did not promote high quality care and support. Quality assurance systems were not robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had not made the required improvement and continued to remain in breach.

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;

- The day of our inspection the registered manager was absent from the service. The provider had put a management support team in to review the quality of care and begin to make improvements. Action plans were shared with CQC and the local authority, however, after a full review of the service the provider withdrew from the service and transferred the regulated activity to a new provider. This was effective from 05 June 2023.
- Systems and processes were in place to monitor the quality and safety of care but were not effectively used. The registered manager completed several audits of the service. These were not always robust enough to identify the issues we found during this inspection including issues relating to the safe management of medicines, and the delivery of good quality care.
- The provider conducted their internal quality reviews of the care and support provided. These identified where some improvements were required but had not ensured these were completed over a twelve-month period. The quality audit considered staff to be competent with the care and support provided, which our findings along with the providers later findings during this inspection demonstrates the governance systems were not robust.
- During a quality visit in February 2022 an improvement was made to ensure all staff had access to electronic care records. We found at this inspection this had not been completed. Both electronic and paper care records were not always accurate. This was an area that was not improved and demonstrates organisational oversight was not effective in driving improvements.
- Managers and leaders within the organisation failed to identify unlawful restrictions of 1 person. Incidents that were required to be reported to the safeguarding authority had not been made as required, and internal reviews of those incidents did not address this. Safeguarding concerns were identified through this inspection by CQC and other visiting colleagues. This demonstrated that the governance arrangements in

place did not ensure people received safe care which protected them from harm.
● Systems and processes were not effective in driving improvement for the overall culture of the service. Managers and leaders did not identify the areas of improvement in relation to the culture of the service and this in turn did not positively shape the culture of the service.
● Some staff told us they felt unable to raise concerns with managers. Staff told us the morale in the service was not good and did not feel supported. Visiting professionals told us leaders within the service were defensive and that the morale and culture within the service was not good. 1 professional said, "Staff feel they can't challenge the management or go against management decisions. It's frustrating on our end."
● We were unable to evidence that care and support was delivered in line with the principles of Right Support, Right Care, Right Culture. This national policy sets expectations for what good care looks like for autistic people or people who have a learning disability. The support provided to people did not enable them to live with the choices, dignity, independence and good access to the local communities most people take for granted. We found the provider operated a closed culture within Nicholas House. People were at times restricted, supported by staff who were not confident or competent, with a management team unaware of the ongoing concerns.
● Professionals who worked with staff told us information was not always provided in an open and transparent manner. An example of this was when staff gave opposing views of a person's day to a professional. One staff said the day had been fine, whereas a second staff member described a significant incident where the person was upset and aggressive.

We were not assured of systems or processes in place ensured the safe and effective delivery of the service. Widespread concerns were identified, which demonstrated a failure of effective systems being placed to ensure service users' needs were met effectively. This was a continued breach of regulation 17 of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
● People, and relatives knew who the registered manager was, although feedback was variable. 1 relative said, "I can speak to [registered manager] if needed, I know how to get hold of them. It is very much [Person] led, I feel happy and content he is looked after and concerns are raised and dealt with," However a second relative said, "The management doesn't spend time with service users and only knows them on paper."
● Staff were not positive and did not feel supported by the overall management of the service. 1 staff member told us about the recent changes and difficulties faced by the registered manager. They said, "For the past week people have been coming from head office. They are starting to implement systems and things can get better. There was a lack of direction before. The previous management was overwhelmed, they were struggling, I do not think they got the support needed." A second staff member said, "It is chaotic, a lack of organisation, the building is not geared for the customers we support, and the training was not in place. Home group as a whole has got the right structure, but not here."
● Relatives told us they did not feel engaged by the management team. They told us their views and opinions were rarely sought and they had given no formal feedback about the quality of care. Meetings for relatives were not held for them to raise issues or discuss improvements regarding the management of the regulated activity.
● The management team were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.
● Where things had gone wrong there was some limited evidence from records to show the registered

manager had worked alongside other agencies to review those concerns.
● Relatives told us that they were not kept informed of when things went wrong. We saw examples of where Duty of Candour applied, but relatives had not been informed, or involved in putting things right. For example with a number of medicines errors, incidents or aggression or staff conduct.

Management had not acted in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. This was a breach of regulation 20 duty of candour of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● Visiting professionals said they did not always feel there was support given to them to provide support or treatment to people. They said there were delays in requesting information and when plans were put in place they were not always followed. There was however evidence that showed the manager was working with other professionals with the relevant referrals made.
● The service was isolated from other services operated by the provider. The registered manager did not seek to attend forums, management learning events through a local voluntary support organisation or other form of 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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care Regulation 9 (1) (2) (3) (A - H) Not all people were supported to make choices to have appropriate control of their daily care to meet their preferences. People were not always supported to engage in activities they wished to enjoy or be part of the community. People were not always able to communicate or express themselves appropriately.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Dignity and respect Regulation 10 (1) (2) (a) (b) Service users were not all treated with dignity and respect. Staff did not always ensure the privacy of the service user; or support their autonomy, independence and involvement in the community of the service user.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent Regulation 11 (1) (2) (3) Care and treatment of service users was not always provided with their consent or in line

with the principles of the MCA 2005.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) (4) (b) Service users were not all protected from abuse and improper treatment. Systems and processes were not consistently operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Care or treatment for service users was at times provided in a way that intended to control or restrain a service user which was not a proportionate response.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Meeting nutritional and hydration needs Regulation 14 (1) The nutritional and hydration needs of service users including preferences and provision of appropriate nutrition was not consistently met.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Duty of candour Regulation 20 (1) (2) The registered provided did not act in open and transparent way with relevant persons when notifiable events occurred.