Sequence Care Limited

Crossbrook Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
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
Crossbrook Court is a care home without nursing providing accommodation and personal care to 12 people at the time of the inspection. The service can support up to 15 people.

People's experience of using this service and what we found
Right Support
The staff did not support people to have the maximum possible choice and control over their lives and be independent. Not all restrictions were considered when looking at the least restrictive options for individual people. Some internal doors were kept locked to all people without considering how the risks for each individual person could be safely supported. The service did not work with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative.

People were not consistently supported by staff to identify and pursue their interests or aspirations. People were not supported to agree plans with clear steps that would support them to develop skills and interests, get jobs or support their sensory needs to enable people to cope with their environment.

Most people had a choice about their living environment and were able to personalise their rooms but not all people were supported to choose their décor and furnishings. The environment was not designed in a way that comfortably supported people to have a choice over when they used communal spaces due to the small size of the rooms.

Staff supported people with their medicines but their approach did not follow best practice to ensure safe administration in a way that promoted independence and upheld people's privacy and dignity.

Right Care
Not all staff understood how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse and some staff knew how to apply it. Incidents were recorded electronically for senior managers to access and review remotely.

The service did not have enough appropriately skilled staff to meet people's needs and keep them safe. This was due to a high use of agency staff which did not support people to receive consistent care from staff who knew them well.

People who had individual ways of communicating, such as using body language, sounds, Makaton (a form of sign language), pictures and symbols could not interact comfortably with staff and others involved in their care and support because staff did not have the necessary skills to understand them.

People did not receive care that supported their needs and aspirations, and did not focus on their quality of life, or follow best practice. People did not have interests that were tailored to them. The service gave people little opportunity to try new activities that enhanced and enriched their lives.

Staff did not accurately or fully assess risks people might face. Where appropriate, staff did not encourage and enable people to take positive risks.

Right culture
People did not lead inclusive and empowered lives because the ethos, values, attitudes and behaviours of the management and staff did not promote this. People were supported by staff who did not understand best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people did not receive compassionate and empowering care that was tailored to their needs.

Staff did not evaluate the quality of support provided to people, involving the person, their families and other professionals as appropriate. People and those important to them, told us they were not always involved in planning their care.

Staff did not ensure risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity. There was a reliance on internal resources, the service had not been supported by the provider to ensure they were aware of and implementing current best practice and guidelines.

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

Why we inspected
We received concerns in relation to fire safety, risk management and the quality of care. We also undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

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

We have found evidence that the provider needs to make improvement. The provider was in breach of regulations in relation to restrictive practices, management oversight, personalised care, how they managed risks to people and staffing levels and skills. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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 work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

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

We have issued four warning notices to the provider in response to breaches of regulations 11 (consent), 12 (safe care and treatment), 17 (good governance) and 18 (staffing). We have imposed a timescale of three months from the date they were served for the required improvements to be completed.

Please see the action we have told the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

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.

Crossbrook Court

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
Two Inspectors, a member of the CQC medicines team and an Expert by Experience carried out the inspection. 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
Crossbrook Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager in post who had applied but was not yet registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with nine people who used the service and five relatives about their experience of the care provided. Not all people who used the service were able to talk with us and they used different ways of communicating including using Makaton, gestures and their body language. We adapted our communication styles as well as making observations of people's responses to communicate with them.

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

We spoke with nine members of staff including the manager and deputy manager.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management, Staffing and recruitment

- Risks to people were not all managed safely. People's care records were not accurate and up to date so they did not help people get the support they needed. Support plans and risk assessments did not offer clear guidance for staff about how to support people. One person's care record stated staff should use 'rough play' and 'deep pressure massage'. Staff had not been trained in this area and related risks of injury to the person or staff member had not been assessed or considered. Another person's care plans and risk assessments failed to identify key information in relation to their diabetes, in addition, another person had no clear care plan for their epilepsy. One staff member told us about a person who screamed a lot and how this had become more frequent. They had not considered to look in to why this might be the case and what the person might be trying to communicate by increased screaming.
- People with diagnosed mental health conditions did not have guidance for staff about what to do in the event of their mental health deteriorating to a crisis situation. One person's mental health needs were labelled as 'challenging behaviour' and how they presented during this time as 'for attention'. Their support plan failed to distinguish the care they required when their mood was low or when experiencing increased depression.
- Staff did not always consider less restrictive options before limiting people's freedom. Each house had a locked toilet which had a sign on it indicating for staff use only. People could not access this toilet in their home without asking staff. In one house the kitchen was kept locked at all times so people could not freely access it. There were some risks to some people in relation to accessing the kitchen, however, how to offer individualised support for people and offer the least restrictive option for each person accessing the kitchen had not been considered.
- One relative told us about how they did not feel their family member was supported correctly. The person had an accident while staff were not with them even though they were funded to have staff support at all times. The relative said, "I was left to explain the incident to the hospital which they did not fully understand as the staff did not [explain it]."
- The numbers and skill of staff did not match the needs of people using the service. The service relied heavily on the use of agency staff to cover gaps in staffing levels. Some agency staff we observed, did not interact with people and were not aware of, or trained in the communication and sensory needs of people they were assigned to support. We observed agency staff not aware of what they should be offering people about how to spend their time. Staff told us they did their best, but they felt under a lot of pressure due to the current staffing shortages and felt this impacted their ability to support people well.

We found risks to people were not being effectively assessed and recorded to ensure staff had sufficient guidance to safely meet people's needs. There were insufficient numbers of suitably skilled and trained staff

on shifts. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded during the inspection. They informed us they would review all risk assessments and support plans to ensure the information was accurate and up to date. They told us they were continually trying to recruit new permanent staff and would review how to assure themselves of agency staff knowledge and competence in practice.

● The provider did ensure that all health and safety checks in the home and fire safety had been reviewed. Maintenance records showed checks were completed by external professionals. Most staff had recently undertaken fire marshall training and other staff had this training booked. Each person had a Personal Emergency Evacuation Plan (PEEP) in place which had been recently reviewed.
● Staff recruitment processes promoted safety. Pre-employment checks were in place and included staff's work history, references and making checks for any criminal records.
● Despite our findings, some relatives told us their family members felt safe at the service and that they would report concerns. One relative said, "If I wasn't happy and didn't feel they were safe I would soon be on to the likes of you and let you know."

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse. Staff had training on how to recognise and report abuse but staff understanding of how to apply this training was mixed. The lack of clear and accurate guidance for staff of how to safely meet people's needs placed people at the risk of unintentional harm.
● The systems in place did not allow for the provider to identify if the relevant authorities such as CQC, had been notified of serious incidents or allegations of abuse in a timely manner.

Using medicines safely
● The service ensured people's emotional needs or distress was not controlled by excessive and inappropriate use of medicines. One relative told us, "I feel since the change in medication by the hospital [my family member] is able to make more decisions themselves."
● People were supported by staff who mostly followed systems and processes to prescribe, administer, record and store medicines safely. We spoke with the manager and staff regarding ensuring temperatures of medicine cabinets were recorded daily and that controlled drugs were correctly signed in and out of the service.
● The service was not currently supporting people to administer their medicines in ways that best promoted their dignity and privacy such as storing and administering their medicines in their bedrooms. The provider policy encouraged this, but the manager informed us this had recently been changed and medicines were dispensed in the office and carried through the house to the person. This could sometimes mean medicines being explained and administered in communal spaces in front of other people living at the service and visitors.

Preventing and controlling infection
● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keeping the premises clean and hygienic.
● The service prevented visitors from catching and spreading infections.
● The service followed shielding and social distancing rules.
● The service admitting people safely to the service.
● Staff used personal protective equipment (PPE) effectively and safely.

● The service tested for infection in people using the service and staff.
● The service promoted safety through the layout of the premises and staff's hygiene practices.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service's infection prevention and control policy was up to date.
● The service supported visits for people living in the home in line with current guidance.
● All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

Learning lessons when things go wrong
● Systems were in place for staff to report and record incidents and accidents. These were reviewed and monitored by the manager and internal senior managers and specialists. However, there was no evidence of lessons learnt from these incidents being shared with the staff to drive improvements to the practice.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff were provided with a variety of training by the provider. The training was not effective as staff were not knowledgeable about the care needs of people they supported or how to develop goals to support and enhance the quality of a person's life. The service checked staff's competency to ensure they understood and applied training and best practice. However, these were not completed or recorded meaningfully. Records showed a lack of understanding by the assessor of people's needs and did not evidence how staff demonstrated competence or were supported to improve their understanding and practice.
- Staff did not receive support in the form of continual supervision and appraisal until recently, this had started to be implemented by the manager but the quality of records completed by supervising staff was poor. There was no detail of what was reviewed and missed opportunities to use the time to support better understanding of best practice for staff. Staff could not all describe how their training and personal development related to the people they supported.

There was a lack of effective staff supervision, assessment and development. Staff did not have the skills and knowledge to provide care using a person-centred approach. This placed people at risk of poor care and unmet needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded after the inspection and informed us they had requested supervisions and appraisal training for all staff members holding supervisory responsibilities. This was yet to be agreed and arranged at the time of the inspection.

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

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

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

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

● For people that the service assessed as lacking the mental capacity for certain decisions, such as consent to care, medicines and treatment, external professionals recorded assessments and any best interest decisions. However, there was no evidence of how the service had determined the person did not have the mental capacity in a specific area as records showed only DoLS applications.
● Not all restrictions had been identified during these assessments. The kitchen in one building was locked to prevent people gaining access without staff. There were considerations to be made about how to support people to safely access the kitchen. We found individual assessments about these risks had not taken place and there were no individual plans as to how to ensure the only restrictions in place were for the people who required them and that those restrictions were the least restrictive methods.
● The toilets in people's homes were locked and had signs on them saying for staff use only. Staff were unclear as to the reason for this, one staff member stating they thought it was for hygiene reasons. The manager told us people had their own toilets in their bedrooms they could use. However, making unrequired restrictions such as having a locked toilet in a person's home was contrary to the principles of the MCA. This practice also promoted a culture of inequality and did not value people or their home.

The provider had failed to properly assess a person's mental capacity for a specific decision and failure to ensure only the least restrictive methods were used to uphold people's rights under the MCA. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded during the inspection and told us for one person, the risks in relation to the kitchen would be reviewed over a time period when risks were fully explored. They had also opened the toilet in one house and was waiting for the sign to be removed. However, this did not address how restrictions were managed for other people and the toilet in one house remained locked at time of this inspection.

Adapting service, design, decoration to meet people's needs
● The design, layout and furnishings in people's home did not support their individual needs. There was not adequate space in the communal areas for the number of people living at the service. We observed one person choose to leave the communal lounge following two other people making comments they did not feel comfortable with.
● People personalised their rooms and some people told us they were included in decisions relating to the interior decoration and design of their home. Other people told us they were not able to input into choosing the colour of the communal spaces.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff completed an assessment of each person's physical and mental health either on admission or soon after. Two people were in the process of moving into the service at the time of the inspection and were having transitional visits to the service to get to know the other people and staff team. Risks to people had been identified but not yet fully explored as to how to support them in the least restrictive way.
● Support plans set out current needs but did not demonstrate evidence of planning and consideration of the longer-term aspirations of each person. There were no clear pathways to future goals and aspirations, including steps of how to teach new skills in people's support plans.

Supporting people to live healthier lives, access healthcare services and support

● People had health passports which were used by health and social care professionals during appointments. Most input was from the providers Internal multi- disciplinary team to assess health needs. One person had been supported to lose weight and told us they had been for an annual health check. Another person told us they saw dentists and doctors. One relative told us, "When [my family member] was in hospital a staff stayed with them 24/7 the support was very good."
● However, there were no health action plans in place to identify and support people to work towards goals to be healthier or stay healthy. For example, one person who had recently had surgery did not have any information about how to manage aftercare and pain management.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink enough to maintain a balanced diet. Each person had been assessed by the provider's internal Speech and Language Therapists (SALT) to identify and choking or specialist dietary needs.
● Staff supported some people to be involved in preparing and cooking their own meals and have a drink or snack but this was only possible once staff had unlocked the kitchen, so people had to ask. Some people had kitchenettes in their bedrooms where they kept their own snacks.
● Staff encouraged people to eat a healthy and varied diet to help them to stay at a healthy weight. People were able to eat and drink in line with their cultural preferences and beliefs, for example, one person followed a Halal diet due to their faith.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People received kind and well-meaning care from staff. One person told us, "It feels like a family, everyone gets on with everyone." However, staff did not always use appropriate styles of interaction with people that supported the ways they preferred to communicate.
- Some language used by staff in records and in person was child-like and not always respectful or valued people as adults. For example, mentioning the use of 'toys' and 'play' and '[person] complied with every instruction by staff' and 'if [person] is triggered.' A relative told us, "The staff are rude to me, the staff say to me, "You don't know [my family member]; we know them." This demonstrated staff did not value people and their relatives and view them as equals.
- People were supported to follow their religious beliefs by attending religious services of their choice and observing related cultural requirements such as diet and personal care. However, not all staff were focussed and attentive to people's emotions and support needs such as sensory sensitivities. We observed one person become very upset at being brought back from church before the service had begun as the staff member had judged they would not cope with the crowd. There was no evidence to support this judgement nor forward planning in regard to attending a church on a Sunday morning which would likely have large crowds of people. The action by the staff member had resulted in the person becoming distressed and not understanding why they could not stay.

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

- Staff did not take the time to understand people's individual communication styles or support people to express their views using their preferred method of communication. Only three people out of a potential 10people (at the time) had been supported to respond to an annual survey asking for feedback. One person had requested support to seek employment in this feedback but 4 months later, there was no evidence this had been actioned.
- People had keyworkers whose role was to act as the main point of contact for the person they were supporting, their relatives and professionals. However, none of the relatives we spoke with knew what a keyworker was or if their family member had one. One person told us, "I have a keyworker. We have sessions but I haven't had one for months." This demonstrated a lack of support for people and their relatives to have a voice about what they think about their care.
- People, and those important to them, did not all take part in making decisions and planning of their care and risk assessments. One person told us they helped to plan their annual review while other people told us they were not involved. Records did not evidence how people were supported to understand decisions and be involved in this process. Feedback from people's relatives was mixed as to how involved they were. One

relative told us, "[Staff] don't really now [involve us in reviews]." Another relative said, "Staff do not listen to anyone, they do what they want. This issue is on-going."

Respecting and promoting people's privacy, dignity and independence

● People did not have the opportunity to regularly try new experiences, develop new skills and gain independence. Some people were supported to be involved in some cooking and cleaning skills. These opportunities did not use a consistent approach by staff and people did not have a skills teaching plan which identified targets, goals and aspirations and supported them to achieve greater confidence and skill.

● Staff did not routinely seek paid or voluntary work, leisure activities and widening of social circles. One staff member told us of a person who wanted a job making tea for people. This person had been supported to gain a voluntary role in a charity shop which had failed as the role did not involve making tea and was not what the person had wanted. There was no further evidence this had been reviewed to look at promoting independence and employment in areas of interest and structured to ensure a higher likelihood of success. People were not supported in ways that respected them as equals. Language used promoted a culture of viewing people as children or of the way they expressed themselves as negative. People were not always included in the planning or reviewing of their care. The provider failed to ensure people were supported to develop skills aiming towards becoming more independent. This was a breach of regulation 9 (Person Centred Care) 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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.
Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication 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

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

● Observations of practice, discussions with staff and care records demonstrated that person-centred approaches were not understood. People were not supported in ways that promoted quality of life outcomes. People's outcomes were not monitored or adapted as a person went through their life. Internal specialist staff provided the service with communication plans, and sensory assessments. However, the content did not always match the information in support plans and risk assessments and was not implemented in practice.
● Staff had not been supported to understand how to turn the information from assessments and plans into practical and consistent approaches to support people's sensory needs and aspirations.
● The communal spaces such as lounge/dining rooms were too small to enable everyone living in the service to comfortably share the space at the same time should they choose to do so. The size of lounges did not allow for people to move away from other people or the noise levels.
● Staff did not provide effective skills teaching or programmes for how people wished or needed to plan their day that was tailored to each individual. People told us they wanted to do more and get out of the house more. One person told us, "I am hoping to go to a day centre soon. The last one was too expensive." Another person said, "I go out shopping and on a minibus. I would like to get a bank account and would like a café job or a job in Lidl. I want to earn my own money."
● People were not supported to identify and achieve meaningful goals. A person told us, "I like swimming, the gym, bowling and going to the seaside. I haven't been to the gym. I used to go swimming, but no-one's sorted that out." Another person said, "I can't go to the park as I cannot walk much and there is only one staff member who can drive the car."
● Relatives told us they did not feel their family members had enough to do and that this impacted on their wellbeing. One relative said, "The staff do not listen to me. I feel there is not enough activity during the day for [my family member] to do. This means their sleeping pattern is wrong, if there were things to do, they would sleep at night." Other comments by relatives included, "[My family member] is not prompted to go to the toilet as it is easier for staff to use [continence] pads. When they were living at home, we always

prompted them, [my family member] is very wet at night. Why not prompt them to use the toilet?" "Staff find it difficult to take [my family member] out due to the noise, but they need to go more, need a change of scenery." And, "We are making plans to visit other family members as something for [my family member] to do."

● People had communication passports that detailed preferred methods of communication. This including using 'now and next' boards, Makaton, pictures and objects. However, staff were not observed to be using these communication tools and told us they did not have the training to offer choices tailored to individual people using a communication method appropriate to that person.

● Some information for one person had been translated into their first language and some guides were in simple English with photo symbols. This was not consistent across all information and all people. Other information and people's care plans were not in formats that people's assessments said they needed such as the use of pictures or Makaton symbols. Another person's records said they also spoke a second language, but staff were not aware of this. One staff member spoke this language so there had been a missed opportunity for them to use it and to teach other staff some key phrases.

● Staff were not committed to encouraging people to undertake voluntary work, employment or vocational courses in line with their wishes and to explore new social, leisure and recreational interests.

● One person, whose care records stated they needed regular time outdoors was observed to be inside the house all times on days inspectors were present. Other people told us they did not go out regularly and mostly it was for local walks, drives or trips to the shop.

People did not receive quality, structured, personalised care that gave them choice and control and supported aspirations and social inclusion. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who were living away from their local area were able to stay in regular contact with friends and family via telephone and social media.

Improving care quality in response to complaints or concerns

● People, and those important to them, could raise concerns and complaints. One person said, "Staff are good, agency [staff] are ok but if you have problems you go to the [permanent] staff." The staff provided a version of the complaint's procedure to people in simple English with photo symbols to help them understand. However, there was no evidence of complaints being analysed to look for lessons learnt and make improvements to practice.

End of life care and support

● People had been supported to review their wishes for the end of their life. Most decisions had been made for people by their relatives.

● One person's care records said they had decided not to be resuscitated should lifesaving treatment be required. There was no evidence of a formal do not attempt cardiopulmonary resuscitation form (DNACPR) being completed and in their file. Without this form, medical professionals would not be able to uphold this wish and would be obliged to perform resuscitation techniques.

Inadequate

Is the service well-led?

Our findings

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

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

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

- Governance processes were ineffective and did not help to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. Audits of care, records and medicines and observations of staff practice took place but had not identified the significant shortfalls we found at this inspection in relation to the quality of care, lack of structured personalised plans, risks to people, the lack of suitable skills and knowledge of staff and restrictive practices. Nor did they use the information to better improve practice and promote positive outcomes for people.
- A person-centred culture with clear outcomes for people was not promoted by staff. People told us they were not supported to do the things they wanted on a regular basis if at all. One person told us, "I am waiting to hear about a job." Another person said, "I like my friends but do not see them." A third person said, "I like shows and cinemas. I would like to do more."
- One relative told us they felt the need to visit unannounced in order to get a better understanding of what was happening at the service as they did not feel confident the support was meeting their family member's needs.
- The manager and staff team did not demonstrate they had the skills, knowledge and experience required in relation to supporting Autistic people and people with learning disabilities. They did not perform their roles effectively or demonstrate a clear understanding of people's needs and oversight of the services they managed.
- The provider and manager did not keep up to date with national policy to inform improvements to the service. They were not aware of current best practice guidance such as CQC's policy on Right support, right care, right culture or the quality of life tool now used when inspecting services supporting people with learning disabilities or Autistic people.
- The quality of staff supervision and observation records were poor. There was little evidence of what had been discussed or observed and there were missed opportunities in supervision to support development of staff knowledge.
- Records of observing staff practice demonstrated a lack of understanding of how to conduct an assessment as well as what people's communication and sensory needs were. Most areas of staff practice had been marked as 'outstanding' despite staff not using people's communication tools and having no structure in place. The area for valuing people for one person had been marked as not applicable. This further demonstrated that the culture of the service did not value people as equals or promote person centred care.

● The provider did not evidence a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.
● Senior managers and other internal specialists spent time in the service but had not identified the concerns we found during the inspection or recognised that practice failed to follow current best practice guidance. The reliance by the provider on internal resources, created the risk of the service having a 'closed culture' where providers are not challenged or supported by external professional to ensure current best practice is implemented.

Systems were either not in place or robust enough to demonstrate the service was effectively managed. The provider failed to identify concerns in relation to records, staff competence, restrictive practices and quality of care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager responded after the inspection and told us they had requested training in these areas for all senior staff from the provider and this was being arranged but no date was yet agreed.
● The manager had been in post just two weeks at the time of the inspection. They were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. The manager was a temporary manager who planned to be at the service until a permanent manager could be recruited. This meant there would be continual instability of management at the service for the foreseeable future.
● Relatives views about management was mixed. Some felt good management had been inconsistent. One relative told us, "The service lapsed when the manager left. [My family member] is now told by staff, 'you can't go out until you stop screaming.'" Another relative said, "The new manager is very experienced and says the things that we would expect."
● Staff felt able to raise concerns with managers without fear of what might happen as a result.

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 manager applied duty of candour where appropriate. The manager identified that a notification detailing an allegation of abuse had not been submitted to the CQC in a timely manner. There was over six weeks between the allegation and the CQC being notified. Systems in place to ensure provider oversight had failed to identify this sooner and the service had not therefore been open with the CQC at the time of the allegation. Notifications are a legal requirement and CQC use the information in them to assess the action taken and analyse risks to people using regulated services.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider sought feedback from people however the data was inaccurate stating that 100% of people had responded, when in fact only three people had responded out of a potential 10 (at the time of the survey). One person had requested support in the survey to get a job but four months later there was no evidence they had been supported to work towards this.
● Relatives told us they had not been asked for their views about the quality of care at the service or suggestions for improvement.
● Staff told us they could talk to the manager but did not always feel listened to by the provider and did not think the provider understood the pressure they felt on shift to meet people's needs while short of staff.

The provider had failed to seek feedback from all stakeholders. Where feedback had been recorded, the provider had failed to ensure staff had acted on this to develop the quality of care. This was a breach of

regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- Staff and the provider did not implement local and national quality guidance from health and social care professionals and agencies to improve care and support for people using the service.
- The service worked with some health and social care professionals for specific reasons such as when people were moving in or out of the service or where there were concerns but most on-going support was sought from internal resources.

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 People did not receive quality, structured, personalised care that gave them choice and control and supported aspirations and social inclusion.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to properly assess a person's mental capacity for a specific decision and failed to ensure only the least restrictive methods were used to uphold people's rights under the MCA.

The enforcement action we took:

We have served a warning notice against the provider. We have given a three-month timescale for the concerns found during the inspection in relation to this regulation to improve in line with current accepted regulations, standards and statutory best practice guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found risks to people were not being effectively assessed and recorded to ensure staff had sufficient guidance to safely meet people's needs. There were also insufficient numbers of suitably skilled and trained staff on shifts.

The enforcement action we took:

We have served a warning notice against the provider. We have given a three-month timescale for the concerns found during the inspection in relation to this regulation to improve in line with current accepted regulations, standards and statutory best practice guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate the service was effectively managed. The provider failed to identify concerns in relation to records, staff competence, restrictive practices and quality of care.

The enforcement action we took:

We have served a warning notice against the provider. We have given a three-month timescale for the concerns found during the inspection in relation to this regulation to improve inline with current accepted regulations, standards and statutory best practice guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of effective staff supervision, assessment, induction and development. Staff did not have the skills and knowledge to provide care using a person-centred approach. This placed people at risk of poor care and unmet needs

The enforcement action we took:

We have served a warning notice against the provider. We have given a three-month timescale for the concerns found during the inspection in relation to this regulation to improve inline with current accepted regulations, standards and statutory best practice guidance.