Sutton Court Homes Ltd

Sutton Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sutton Court is a residential care home for people living with a learning disability and autistic people. It is registered to provide personal care for up to 10 people; at the time of inspection 10 people were living at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities 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 or autistic people.

People's experience of using this service and what we found
The service could not show how they met some of the principles of Right support, right care, right culture. The model of support did not always promote maximum choice and independence. The ethos, attitudes and behaviours of managers and staff did not always ensure that people lead confident inclusive and empowered lives.

People were not always protected from abuse and poor care. Staff had failed to report safeguarding incidents. The provider had not ensured managers and staff had suitable training, skills and knowledge to support people whose behaviours may challenge themselves or others safely in least restrictive and most person-centred way.

The service did not focus on people's quality of life and care delivery was not always person centred. Staff knew people well and often showed kindness but they did not always recognise how to promote people's rights, choice and independence. People's human rights were not always upheld. Care and activities were not planned or delivered in a way that met people's individual needs.

People's communication needs were not always met and information was not shared in a way people could understand.

People were not supported by managers and staff who understood best practice in relation to learning disability and/or autism. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their individual needs. Medicines were not effectively checked, and errors were not reported. Risk assessments in relation to health and safety were not always undertaken.

Some people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service were not always understood by managers and staff.

People and relatives gave mixed views of the service. Some people had lived at Sutton Court for many years and told us they were generally happy with the support, one person told us they would like to move, and some people were unable to express an opinion. One person said they liked to have support from female staff and this was what they got.

People told us they enjoyed the meals and had a range of foods available to them.

People told us they received appropriate health care supported by staff and told us about treatment they received. Managers had taken steps to support people who needed it to be more confident when attending health appointments.

People told us they had access to independent advocacy and staff supported people to maintain links with those that are important to them.

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 good (published 31 January 2019). The service has been rated requires improvement.

Why we inspected
The inspection was prompted in part by notification of a specific incident of alleged physical abuse. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. We inspected to provide assurance the service was applying the principles of Right support, right care, right culture. The inspection was initially a targeted inspection in response to risk, we expanded this into a comprehensive inspection to look at all the five key questions due to further concerns identified.

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

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Following the inspection the provider has taken some actions to mitigate the risks. This is an ongoing process.

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 identified breaches in relation to person-centred care, safe care and treatment, safeguarding, staffing and governance at this inspection.Please see the action we have told the provider to take at the end of this 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.
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Inadequate**

Sutton 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one specialist advisor (pharmacist).

Service and service type
Sutton 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.

Notice of inspection
The 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. 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 spoke with seven people who used the service about their experience of the care provided. We spoke with seven members of staff including the provider, registered manager, the local home manager for Sutton Court and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two relatives and we sought feedback from professionals who work with the service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse.

- People were not safe from abuse. Systems and processes to protect people from the risk of abuse were not operating effectively. Staff practice failed to demonstrate an understanding of their responsibilities for identifying and reporting concerns.
- During the inspection we observed staff practice that led us to raise a further safeguarding concern. This was witnessed by other staff, who did not raise the concern because it was not recognised as abuse. When we raised it with the registered manager and asked what they would do to protect the person, they said "I will talk to the staff." When pressed they suggested they would offer training to the staff member. The registered manager then sought advice from the provider who suspended the member of staff from work. We then had to remind the registered manager to report the incident to the local authority safeguarding team. The original safeguarding concern that had triggered this inspection had not been reported by staff who had witnessed it.
- The service had enough staff, who knew people who used the service. However, staff did not understand restrictive interventions included restraint, segregation and seclusion. This placed people at risk of harm. For example, staff members did not recognise they were using restrictive practices by telling people to go to their room. This meant that people were at risk of feeling punished for expressing themselves. However, we did find that staff then stayed with the person in their room until they were calm.

The provider failed to ensure people were safe from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People could not always have confidence they received the correct medicines at the right time. We found one person had a new medicine dispensed, which had not been given to them for 10 days following the date it was available. Which meant treatment for a significant condition was delayed. Staff had not followed systems and processes, including the provider's own policy, to safely order, receive, administer, record and store medicines.
- We carried out a full stock check of medicine and found that five people had discrepancies in the stock of medicines they should have. This meant that people did not always get their correct prescribed doses. These were medicines prescribed for significant conditions and meant there could be a potential detrimental impact on people's health. The registered manager did not carry out or record weekly stock checks effectively which could have identified the errors.
- People were placed at risk of receiving 'as required' medicines inconsistently. 'As required' medicine (PRN) did not always have a protocol in place to guide staff describing what the medicine was prescribed for or details such as dose instructions, signs or symptoms about when to offer the medicine, interventions to use

before medicines offered. When to review the medicine and how long the person should expect to take it.
● Staff had not followed a person's epilepsy plan which stated that the GP or 111 telephone line must be called following three seizures in a 24-hour period. The person had five seizures in one 24hour period with no medical advice sought. This meant that the person did not receive medical attention they may have needed.
● Medicines were found to be stored on a locked trolley in the general office. However, staff members were observed preparing medicines in this area; it was not clear how IPC standards were applied as there were no hand washing facilities in the area. The trolley did not appear to have been cleaned and the tray on the top of the trolley where medicines were prepared was soiled. People's internal and external products we stored alongside each other in plastic tubs inside the locked trolley.
● Medicines were not recorded on the medicine administration records (MAR) in accordance with National institute for clinical excellence (NICE) guidance. Handwritten records should only be produced in exceptional circumstances and be signed by two trained and competent staff. This was not the case for some MAR charts. Lack of accuracy checks could lead to give the incorrect prescribed medicine or dosage.

The provider failed to ensure safe care and treatment. This was a breach of regulation 12 (proper and safe management of medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Information about medicines was not always available in an accessible format. However, some people were able to talk about their medicines, this knowledge was a combination of verbal explanation from staff and health professionals. People's medicines were regularly reviewed by health professionals to monitor the effects on their health and wellbeing. People had annual health checks with their GPs. People had health passports in place. Health passports are documents giving details of a person's support needs such as communication and give a background of the person's health history. These are given to hospital staff if a person is admitted to hospital.
● Leaders understand and implement the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensure people's medicine was reviewed by prescribers in line with these principles. We saw evidence of use of antipsychotics being reviewed and reduced where appropriate. Antipsychotics are used for some types of mental distress or disorder and heightened anxiety.

Assessing risk, safety monitoring and management and learning lessons when things go wrong
● People's care and support was not provided in a safe and well-maintained environment. Autistic people did not have assessments of their sensory needs. This meant the environment had not been adapted to meet people's sensory needs and reduce negative impacts on people from the environment.
●Risks to people from fire were not adequately assessed or mitigated. For example, fire doors were wedged open and would not be able to automatically close in the event of a fire, allowing fire to spread faster. The provider's fire contractor had recommended automatic door closures be fitted on their report in January 2021, this had not been done. The registered manager told inspectors "we don't always follow recommendations." This was raised with the provider who did arrange for some door guards to be fitted on the second day of inspection. However, the kitchen door was still wedged open on day three of the inspection. One person wedged their bedroom door with a book. The Home manager confirmed a risk assessment had not been carried out.
●Personal emergency evacuation plans (PEEPs) for everyone were limited in detail and each instructed staff to evacuate people to the service vehicle, which was parked in the front drive of the property if fire happened at night. This practice had not been risk assessed. The provider gave assurances during the inspection this would be addressed.
●The service recorded all incidents where people's actions could harm themselves or others. Managers reviewed these incidents but did not effectively analyse them to identify why the incidents had occurred.

Staff were not routinely offered structured debriefs following incidents. Debriefs are an opportunity to reflect and discuss in depth what happened and what areas of support were effective or not and acknowledge feelings. Learning from this was not taken forward to reduce the likelihood of the incident reoccurring

The provider failed to ensure safe care and treatment. This was a breach of regulation 12 (assessing risk to health and safety) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. Staff were not wearing face masks consistently. Practice at lunch times was for staff to eat with people, no masks were worn during this time. We spoke to the registered manager and provider and they changed the practice to be in line with the guidance. We saw that this practice had stopped during the inspection.
- We were assured that the provider was preventing visitors from catching and spreading infections. Visiting was in line with current guidance. Visitors took a test and used PPE. People and relatives confirmed they were satisfied with the arrangements and were kept informed of changes.
- We were somewhat assured that the provider was meeting shielding and social distancing rules. People are not all able understand the need to socially distance. Everyone ate together in a small dining room. However, there had been no cases of COVID-19 and no one has had to isolate. Everyone has had two vaccinations and took part in regular testing.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
- We were assured that the provider was admitting people safely to the service. There had been no new people admitted to the service since the start of the Covid-19 pandemic.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment

- Staff were recruited safely. The provider carried out appropriate checks before they started working at the service.
- People told us they had enough staff in the building if they needed help. One person had a staff member with them all the time during the day and the provider was seeking additional funding for another person to have additional staff time.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience and assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People were supported by staff who did not always use best practice for people with a learning disability and autistic people. Records showed some staff had worked at the service a long time and had not received relevant training for many years. Half of the staff team had not received any training to support people with a learning disability or autistic people. For example, a staff member with the most recent training was asked about what they had learnt about autism, they said, "They like routine." They gave no other comments.

● Staff were not all trained or had the relevant knowledge to meet people's communication needs, for example, three people had recorded need for staff to use sign language to communicate. We observed people using signs but saw very little staff using signs to support their speech. We observed this being used inconsistently by staff members working with the person. Staff told us there were some books with symbols in the kitchen and office, but they had no training to use them.

The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Managers and staff lacked understanding around good care practices and how to meet people's needs. For example, one person persistently refused offers to go out to activities, staff had not supported the offer with pictorial communication tools or used the person's preferred method of communication in any meaningful way. Staff had not considered for some people the change from one activity or environment to another could be distressing. The person's relative told us they couldn't understand why their relative refused to go out from Sutton Court. They said. "He comes out with us; it's how you approach it with him."

● People did not have communication or sensory assessments. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care. Consideration had not been given to the function behaviours that may challenge others or self-injury may have for people and not sought or carried out functional behavioural assessments. A referral was made to a health professional for behavioural support however the person was discharged from them in December 2020, a further 19 incidents were recorded subsequently, no further referrals were made.

● Managers told us that they looked at the incident reports but could not see any trends or triggers. It was clear from our review of the incident records that there were both trends and potential triggers which would help identify why this person was getting distressed. The registered manager spoke of one person's self-injury. "It is historic you cannot do anything about it." This demonstrated that managers were not keeping

their own knowledge and training up to date with current best practice to lead by example. or seeking to improve it.
● People did not have individualised care in line with their preferences and assessed needs. For example, drinks were served at specific times of the day in the dining room. We were told by managers; people could have drinks at any time; this did not happen during the inspection. Staff told us, "This was because people liked routine." All drinks at mealtimes were served in plastic cups and there was only one type of drink on the table.
● People's human rights were not always upheld as staff did not always support them to be independent and have maximum control over their own lives.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff had regular supervision and appraisal. Managers provided an induction programme for any new or temporary staff.

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

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

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

● Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards. However, staff were not consistently applying the principles. For example, staff were not always using people's preferred methods of communication so could not be confident that people had all the information they needed to make a decision.
● People who were assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decision.
● People had an authorised DoLS and the registered manager had a system to follow up with the local authority when it was due to expire. Some people told us they knew their DoLS assessor and understood why a DoLS was in place.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people were supported to make their own breakfast and lunch. Staff mainly prepared and cooked most meals. Shopping was ordered by staff using the menu agreed with people for that week.
● Staff supported people to choose the menu for the week from photographs of meals. People were offered alternatives if they did not like the meal the group had chosen.
● People told us they enjoyed the meals and had plenty to eat.

● There was a good selection of fruit and vegetables available.

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

● Efforts were made to support people to understand the need to attend health appointments and support was given to people who had anxiety about this, including just popping into the GP practice to say hello to build up trust and reduce anxiety.

● People had good access to physical healthcare and were generally supported to live healthier lives.

● Some people told us about their health conditions and had detailed knowledge of their treatment.

Adapting service, design, decoration to meet people's needs

● Autistic people had not had sensory assessments so there had been no adaptations made to the building. There were no pictorial supports displayed such as a photo display of staff on duty. This was raised with managers, who told us they would seek referrals for sensory assessments.

● People appeared comfortable in their environment and spent time in their own rooms, communal areas and the garden. People had their possessions in their rooms. Two people were keen to show us their rooms and pointed out the things that were important to them.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● People gave mixed views about the staff. One person said they liked most staff but named one staff they did not like saying, "I don't get on with (name), she doesn't communicate with me she is argumentative." "They ignore me and I have to shout at them." "If they have a bad day, they don't talk to me." Another person said, "They are alright" and another told us, "I like it here they are good to me."

●People were not always treated with dignity. Staff used the term "kick off" when referring to someone who was emotionally distressed. People's privacy and dignity was not always promoted and respected by staff. We observed a staff member asking a person if they had used the toilet in a busy communal area.

● We observed the majority of staff interactions with people were kind and friendly.

●People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy. Staff knocked on people's doors and waited for permission before entering.

●People had access to independent advocacy for support with specific issues. People told us they met with their advocates and they could talk to them. Since the beginning of the COVID-19 pandemic appointments were arranged by staff. One person told us they could contact their advocate and staff would always help them to do so.

● Staff supported people to maintain links with those that are important to them. One person told us they were going to visit their family now the Covid-19 guidance on going out had been changed.

● People told us they had monthly group meetings with managers to express their views and talk about changes in the house.

●Staff maintained contact and shared information with those involved in supporting people.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

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

- Mangers and staff did not always work in a person-centred way to meet the needs of people with a learning disability and autistic people. They did not always follow best practice and the principles of Right support, right care, right culture and were not ensuring that these principles were carried out.
- Staff mostly carried out tasks rather than engaged people and encouraged independence. For example, they often cleaned, did laundry and cooked meals for most people rather than with them. Some people were encouraged to do some of these tasks for themselves, but this was the exception. One person told us that staff cleaned their room and did their laundry, when asked if they could do this for themselves, they responded, "It's the staff's job."
- People had support plans that were named 'positive behaviour support plans' (PBS). A positive behaviour support plan is a care plan to help understand and support people who are perceived to display behaviour that they or others find challenging. These plans did not include actions to improve people's quality of life, the function of a person's behaviours for the person, any skills teaching to support the person to have an alternative way to express themselves when emotionally distressed or for some people clarity about how to effectively communicate with them. Which meant managers and staff did not have effective strategies to support the person.
- People had a limited range of activities to choose from and often relied on enough staff and transport being available. For example, four people go to a swimming club on a Wednesday one week and a different four people go the following week. This was because of capacity of the staffing and transport. Activities mostly happen in groups.
- We observed a swimming session where people were enjoying the activity and had the opportunity to meet friends and socialise. This was an activity where attending more frequently could enhance people's quality of life experiences.
- People's plans did not contain goals they could work towards to support independence, self-worth or aspirations they might have. Plans focussed on the things the person cannot do and little consideration is given to their skills, achievements, interests or hobbies.
- People were not supported to take positive risks to promote independence.

Meeting people's communication needs

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

● People's communication needs were always not met, and information was not shared in a way people could always understand. When asked the registered manager told us they use a programme that replaces words with symbols for meeting notes with people. When asked if people could read or understand these symbols, the registered manager was not able to confirm they could.
● The service had very limited accessible information such as signs and pictures. The only picture supports were for the once a week menu planning. When asked about other picture supports for communication, we were told "we tried some, they did not work."
● Support plans were not accessible to people. For example, there were no use of symbols or photographs and plans were kept on an electronic system which was not available to people.
● People had communication support plans, but these did not include important information. For example, one person's record stated staff should encourage them to make choices but did not explain how staff should do this.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● The provider did not focus on people's quality of life outcomes. During the inspection people were seen to have sedentary lifestyles and spent long periods with little stimulation. One relative told us, "(Name) does colouring and watches DVD's, not much else. They did eventually get horse riding arranged but then COVID-19 came."
● People did tell us they went out every day to a limited range of activities. Managers told us they had recently arranged a cycling activity for a group of people, which they enjoyed and would try to do more of this. However, this was not based on people's individual choices or interests.

Improving care quality in response to complaints or concerns
● The provider had a system for responding to concerns and complaints. The registered manager told us they had received a complaint from a member of the public about people on a group walk not wearing hats in the rain. The registered manager said she had acted upon it by instructing the staff not to arrange walks at school leaving times. The registered manager's action had meant that the times people could go for a walk were restricted and gave the impression the action was taken to avoid complaints rather than addressing the actual concern about appropriate clothing for the weather conditions.
● Some people and a relative told us they could raise concerns. "Happy to talk to (name) if I was concerned." "Communication is very good". However, another relative told us communication was not good.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The provider had failed to ensure that all managers and staff recognised and reported abuse or restrictive practices.
- Governance processes were not effective and did not always keep people safe, protect their human rights and provide good quality care and support. For example, leaders had not identified that weekly stock checks of medicines were not being carried out or recorded effectively.
- The provider had not ensured managers and staff had the information and training they needed to provide safe and effective care, and follow best practice for supporting autistic people and people with a learning disability.
- Leaders were out of touch with what was happening in the service. They did not have effective systems that ensured service delivery was person-centred and met best practice for supporting autistic people and people with a learning disability.
- The provider had not ensured management and staff understood the principles of good quality assurance. For example, incidents were not analysed and did not include lessons learnt to inform practice development.
- Information to enable monitoring was unreliable. Record keeping was sometimes poor. For example, staff did not always record people's experiences.
- The provider's vision and values were not clearly expressed to staff and not understood for example the behaviour and medicines policies were not being followed.
- General environmental risks had not been assessed or mitigated. The registered manager could only produce two environmental risk assessments, one for scaffolding and one for new drive being laid. There were no risk assessments for trips, slip and falls, for use of electrical equipment, smoking, ice and snow, heat waves or any other potential environmental risks. This meant the safety of both people and staff in the environment had not been fully considered.
- There was a lack of effective oversight and monitoring of the service. For example, strategic governance and quality monitoring processes had failed to ensure compliance with government guidelines for working safely in care homes during the COVID-19 pandemic by ensuring that staff wore face masks when in close contact with people.
- The provider had failed to act on advice from their own fire equipment contractor and left fire doors wedged open. Action was taken after it was raised by inspectors.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt respected, supported and valued by managers and the provider.
- The service apologised to people, and those important to them, when things went wrong.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and support was appropriate to meet people's needs.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure safe care and treatment. (proper and safe management of medicines and assessing risks to health and safety)

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were safe from abuse and improper treatment.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs.

The enforcement action we took:

Impose a condition