Matthew Residential Care Limited

Matthew Residential Care Limited - 1 Milton Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Matthew Residential Care – 1 Milton Avenue is a residential care home providing care to five people with learning disabilities at the time of our inspection. The service can support up to five people.

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.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
The service did not effectively support people in relation to recognised models of care for people with a learning disability, autism and behaviours that challenge, such as positive behaviour support approaches (PBS) and supports to engage people in relation to their communication needs. As a result, whilst we saw features of positive support, including choice, participation, and inclusion, these were not consistent.

Right care:
People's care plans failed to include important information in relation to needs such as epilepsy, diabetes and behaviours considered challenging. Behaviours that challenge are a product of an interaction between the individual and their environment. Functional assessments and evaluations had not been carried out to understand the reasons for people's behaviours. Therefore, without a comprehensive understanding of people's needs, care was not always person-centred.

Right culture:
Staff and managers had not received training in managing behaviours that challenge and how to support and reduce anxieties and triggers for behaviours. Staff and managers had not explored the use of communication tools to fully engage people in making decisions. The absence of communication plans and strategies to ensure the environment was predictable to people increased people's dependence on staff for their basic needs.

The failure to fully meet the underpinning principles of Right support, right care, right culture, meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

People's medicines were safely stored and generally well recorded. However, there were no protocols for medicines prescribed 'as required' in relation to reduction of behaviours and anxieties. People's records did not show if alternative methods of behaviour management had been explored before medicines were given to people.

Some staff had not received regular supervision. Staff training records showed that required mandatory training had not always been recorded as having taken place. Managers and staff had not received training in people's specific needs, such as positive behavioural supports, epilepsy and diabetes.

People's care plans, risk assessments and care records did not include information relating to their current needs, for example, in relation to epilepsy and diabetes. Monthly reviews of care plans had not taken place since September 2021.

Activities provided to people were limited, and we did not observe choices being offered by staff. There was no evidence that accessible communication tools such as visual communication methods had been explored and used. Staff had not received Makaton training to support a person who used this as a means of communication.

The service's quality assurance monitoring had failed to identify failures in relation to a fire door closure and access through a padlocked gate to the fire assembly point should there be a need for an urgent evacuation. Fire drills had not been carried out. Hot water temperature checks had not been carried out to reduce risk of scalding. Further failures in relation to care plan reviews, care records, including behavioural monitoring and staff supervision and training had not been identified through the quality assurance procedures.

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 on 22 March 2018)

Why we inspected
We received concerns in relation to the management of risk, staffing levels, staff training, the management and leadership within the service and people's personal care needs. A decision was made for us to inspect and examine those risks.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Matthew Residential Care Ltd – 1 Milton Avenue on our website at www.cqc.org.uk.

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 regulation in relation to safe care and treatment, staffing, person centred care and good governance. Please see the action we have told the provider to take at the end of this report.

At the time of the inspection the service had enlisted input from a consultancy company, and we noted an improvement plan had been developed which broadly mapped ways to address identified risks.

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

Follow-up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective 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 well-led. Details are in our well-led findings below.	**Inadequate**

Matthew Residential Care Limited - 1 Milton Avenue

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection team consisted of one inspector.

Service and service type
Matthew Residential Care Ltd – 1 Milton Avenue 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 registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The initial inspection on 18 November 2021 was unannounced. We gave the service 24 hours' notice of our return visit 26 November 2021.

What we did before the inspection

Before the inspection we reviewed the information, we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people living at the service, three members of staff and the quality assurance manager We reviewed care records of three people to help us assess and understand how their care needs were being met. We also reviewed records relating to the running of the service. These included recruitment and training records for five staff, five medicines records and records related to the provider's quality assurance and management systems.

After the inspection
We spoke with one relative and a local authority representative.

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
• The provider had not always identified, monitored and where possible, reduced or prevented risks to people. For example, the support records for a person did not include a risk assessment in relation to their epilepsy. There was no recorded guidance for staff on how to manage seizures when they occurred. There was no risk assessment and risk management plan for a person with diabetes.
• Behavioural risk assessments for people did not always include information about current risks and how to manage these. For example, there was no risk management plan in place for a person who self-harmed. A person whose risk assessment identified they exhibited behaviours such as aggression, destruction of property and self-harm included some guidance for staff. Their care plan indicated the person had a positive behaviour support plan (PBS). A positive behaviour support plan outlines the supports and strategies to be implemented by team members to reduce the occurrence of problem behaviour through positive and proactive means. However, a positive behaviour support plan was not contained within their risk assessment. The person's behavioural chart contained information only in relation to their behaviours and did not show whether staff had followed the guidance in their risk assessment. The service had not reviewed and monitored their behavioural chart in order to understand patterns and functions of the persons behaviours, and there was no evidence of learning from staff supports and interventions.
• The care record for another person identified they demonstrated behaviours that challenged others. There was limited guidance for staff on meeting their behavioural needs other than that they should be aware of the person's 'whereabouts'. A referral had been made to the local learning disability behavioural support team. However, this was closed due to the service's failure to provide the team with information about the behaviours.
• The service did not always manage the safety of the home environment through checks and action to minimise risk. For example, checks were not carried out to show if water temperature was maintained within acceptable ranges. This put people at risk from scalding. Fire drills had not taken place. A fire door to the kitchen was propped open and did not have a self-closure device fitted in case of fire. The gate from the garden to the fire assembly point was secured with a padlock which meant that, unless a staff member holding the key was with people, they could not easily gain access to the fire assembly point from the back garden.

The above demonstrates a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Regular health and safety risk assessments and checks had been carried out. Servicing of, for example, gas, electricity, fire equipment and appliances had been carried out and were up to date.

Using medicines safely
• The provider had failed to ensure that protocols and staff guidance on the administration of PRN (as required) medicines were in place. This meant we could not be sure people were administered PRN medicines at the right time or if staff were using low arousal techniques to reduce anxiety prior to administering medicines prescribed for the management of behaviour.
• The administration of people's PRN medicines was not always accurately recorded on the chart with the time of administration. People's care notes identified when PRN medicines were given but did not always identify the reasons why or specify the time of administration.
• The service had up-to-date medicines policies and procedures, but these did not include reference to STOMP principles. STOMP stands for stopping over-medication of people with a learning disability, autism or both. Although there was no evidence that people were given PRN medicines on a daily basis, the failure to maintain accurate records indicating if alternative interventions had been tried and found unhelpful prior to the administration of such medicines meant there was a risk of over-medication.
• We noted two people who were prescribed PRN medicines had regular psychiatry appointments where medicines were reviewed, and dosage amended where appropriate. However, this was not the case for a third person.

The above demonstrates a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's medicines administration records were otherwise up-to-date and in good order. People's prescribed medicines were safely stored.
• Staff administering medicines had received appropriate training. Competency checks of administration of medicines had taken place.

Learning lessons when things go wrong
• The service's accident and incident records showed that incidents were linked to behaviours that were challenging to staff or others. However, staff had not always recorded events or environmental issues prior to the behaviour taking place. There was no means of evaluating and identifying causes, triggers and patterns of behaviour which could have provided learning for staff on managing and reducing people's anxieties.
• The service did not review the use of practices that could be deemed as restrictive and look for ways to reduce them. The practice of administering psychotropic medicines as PRN for the primary purpose of influencing a person's behaviour is considered restrictive. The failure to keep detailed and accurate records of people's behaviours and the reasons for administering PRN medicines meant people might be at risk of unnecessary restrictions.
• Even though people demonstrated behaviours that were challenging to staff, managers and staff had not received training in positive behavioural approaches.

The above demonstrates a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• The provider had failed to develop procedures to manage the risk of financial abuse. For example, there were no procedures and processes that underpinned the management of people's money, including risk assessments. Transactions were not countersigned by staff and the person using the service or other suitable witnesses, which meant there was no confirmation of the authenticity of all transactions. Whilst audits were carried out, these were not effective because this was not identified.
• We found, however, that following a recent safeguarding concern, improvements had been made to ensure

people's monies were more securely managed. Daily checks of financial records took place. The provider had been a financial appointee for a person where a local authority had raised concerns about their finances. We noted the provider was taking action to ensure that appointeeship was transferred, including the appointment of an advocate for the person.
• The service had safeguarding policies and procedures and staff were aware of these. Staff had received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. However, there were no recent records of annual refresher training in safeguarding in three staff files we viewed. Staff were aware they could contact the local authority safeguarding team and CQC when needed.

Staffing and recruitment
• The service had recruitment processes in place which supported safe recruitment decisions. This included pre-employment checks to ensure staff were suitable to work with people living at the service, such as references and criminal records checks.
• During our inspection there were sufficient numbers of staff to meet the needs of people using the service. One to one support to a person who required this was provided. However, although there was a full complement of support workers, there was a general shortage of staff because some staff had not been vaccinated against COVID-19 or were awaiting a second vaccination. The service was using agency staff to manage short-term staffing gaps.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff. Staff, including agency staff, were required to show a negative lateral flow test before commencing their shifts. Agency staff were required to evidence they had been vaccinated prior to commencing work at the service.
• 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.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

At the time of the inspection the registered manager was away from work due to sickness. They returned to work following our inspection.

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 there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care plans and risk assessments did not always reflect their current needs. For example, although there was reference to people living with particular health conditions, they did not have care plans or risk assessments providing guidance for staff in relation to supporting their specific health needs.
• Where people had been assessed as having behaviours considered challenging, there was information in their care assessments relating to this. However, whilst these referred to people having positive behavioural support plans (PBS), these were unavailable in their care records.
• Equally, least restrictive strategies in relation to reducing behaviours that challenged were partially adopted. For example, we did not observe people were engaged in meaningful activities. Creating opportunities for meaningful activities is considered a positive intervention, more so in cases were boredom could lead to an escalation of behaviours that challenge. For example, a person's behavioural care plan referred to distraction, but did not specify what distractions staff could use to divert the person from any distress or anxiety.

This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
• Some staff members had received required mandatory training. However, three staff training records we viewed did not show if all mandatory training had been completed.
• Staff had not received additional training in relation to people's specific needs. For example, training in specific health conditions had not been provided. Staff and management had not received training in supporting people with behaviours that challenged and in positive behaviour supports.
• For two staff members, there were no records of supervision with a manager. Three further staff members had received at least two supervision sessions during 2021. However, there were no records of any regular staff supervisions taking place since 2019.

The above demonstrates a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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).

• The service did not clearly record capacity assessments for people identified as lacking mental capacity for certain decisions in line with the guidance associated with the MCA. Best interest decision processes involving the person or their family members and key professionals had not been used where there were concerns about their capacity. For example, best interest meetings had not taken place in relation to management of a person's finances, where they did not have capacity to make decisions about the use of their monies.
• Where required, staff had referred people to the local authority for DoLS authorisations. However, a review of records also confirmed interventions were not always delivered in the least restrictive manner. For example, PRN medicines were administered even though there was no record of least restrictive alternatives having been tried to prevent escalation of behaviour.

The above, was a breach of Regulation 11 (need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• We noted people's care records confirmed referrals had been made to other healthcare professionals, such as psychiatrists, dentist, GP and others. Two people received support from a local specialist behavioural team. However, we saw a letter stating a referral to a behavioural specialist had been closed due to the service's failure to provide requested information in relation to their behaviours.
• People's files did not contain health action plans (HAP) and records of annual health checks. A HAP is a record of a person's health and provides accessible information about what that person needs and wants to do to stay healthy. These can be used to advise health professionals of people's needs and preferences.
• Each person was registered with a GP, but the home had not ensured they received a routine annual health check. Annual health checks provide an important means for routinely checking the general health of adults with learning disabilities and are considered to be best practice.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff supported people to have a balanced diet. They told us people chose their meals and if they didn't want the meal on offer an alternative meal was provided. We observed a mealtime and saw that people ate different foods and appeared to enjoy their meal.
• Staff offered people were offered drinks and snacks at other times during the day.

Adapting service, design, decoration to meet people's needs
• The environment was partially adapted to meet people's needs. A person with mobility impairments had a ground floor room and access to an accessible bathroom. Furniture was sturdy and a communal television was secured to reduce risk of damage. People's rooms had been decorated in line with their individual preferences. Staff told us people were involved in personalising their rooms. One person showed us the cuddly toys and CD player in their room. They said these 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 now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People were not supported to participate in a full range of activities. During our inspection people were not always engaged in activities. One person watched Asian channels on the communal television. Another person used a tablet to play tunes important to them. We spoke with another person who was listening to music in their room. They told us they were going out with the quality assurance manager, but they required repeated assurances from staff that this was going to happen.
• Although people's care records contained activities plans, we saw little evidence these were carried out. Staff told us external activities had been reduced due to the COVID-19 pandemic, but people's activities plans had not been updated to reflect changes. People's care records did not always identify activities they had participated in. For example, one person's care records said, "away from home", but did not specify what they were doing.
• Although people's care plans identified activities to be developed and supported by staff, their care records did not show if and how these had been carried out. For example, one person's care plan identified that staff should support them with development of self-care activities. However, there was no plan or programme in place to support staff and no measurable objectives had been put in place or monitored.
• The atmosphere in the service was calm and friendly when we visited. People appeared at ease with staff, and people who could speak with us confirmed they liked the staff. Staff were observed to respond to people when they requested support. We observed a one-to-one support worker for a person who did not always engage with them. Staff said the person did not always respond calmly when they were spoken with and they looked for cues from the person.
• People's privacy was respected. Support plans described how people should be supported so that their privacy and dignity were upheld. We observed staff knocking on people's doors and announcing themselves before entry.
• The service recognised people's rights to privacy and confidentiality. Care records were stored securely in locked cabinets in the office.

Supporting people to express their views and be involved in making decisions about their care
• There were limited opportunities for people to express their views. Although there was some evidence of meetings and surveys having taken place, these had not been made accessible to people with communication impairments. Actions from such activities had not been recorded, nor was there other evidence of them being followed through.
• People's care plans contained limited guidance for staff on supporting people to make decisions about their care. There was no reference to, or observed use of, tools such as picture assisted information or

objects of reference.
• The service did not have a key-worker system to allow people to speak confidentially regarding issues which were important to them. As a result, there was no platform for person centred meetings to offer a consistent point of contact for people to express views and be involved.

Ensuring people are well treated and supported; respecting equality and diversity
• Some information about people's specific needs in relation to ethnicity, religion and cultural or other preferences was included in their care plans. However, the plans did not provide guidance on supporting these, or whether these needs were essential for the person.
• A person watched Indian movies on the communal television at the home and they told us they enjoyed this. However, there was no alternative television for other people to watch programmes of their choosing.
• People did not have health action plans. Although some people had hospital passports, these had not been reviewed and updated to reflect changes in needs. Hospital passports provide essential information where a person requires a hospital inpatient stay. There were no records showing people had received regular annual health checks. Therefore, we could not be assured people had equal access to health services to ensure their health needs were met.
• Whilst people's plans identified potential equality issues, including communication, these were not addressed effectively. For example, although some people's care plans identified communication impairments or difficulties, alternative formats had not been developed to assist people to make decisions.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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

• People had care plans but, although they contained information about people's communication needs, there was limited information about how they were supported to make choices. We saw people were given choices of clothing and meals. However, people's care plans contained limited information about preferences or how they expressed likes and dislikes. There was little information in relation to supporting people to make decisions about significant issues, such as healthcare, activities and community engagement.

• Our observations showed people were not provided with a wide range of activities to choose from. Daily notes for one person recorded they spent their time watching television. Another person's notes indicated they used their tablet to play music, but few other activities were recorded. We saw a staff member facilitating seated exercises with this person and another. The staff member said, "We do this every day before lunch". However, there was no record of this activity taking place in the person's care notes. People's care plans included weekly activity plans, but these were not followed during the days of our inspection. We asked a staff member about this and they told us that some activities had been stopped due to the COVID-19 pandemic. However, people's activity plans had not been updated to reflect this.

• The care plans for some people did not include information or guidance about specific needs. For example, the care plans and risk assessments for two people did not reflect the support they required in relation to their specific health needs.

• People's needs were not kept under constant review or revised at any time when these needs changed. The service's policy was to review people's care plans on a monthly basis. However, there had been no recorded review since July 2021.

• The impact of interventions in terms of relevant outcomes were not evaluated. One person's care plan identified a range of supports to manage their behaviours. However, these supports were not recorded on their behavioural charts and there had been no evaluation by the service.

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.

• The service did not always ensure people had access to information in formats they could understand. Support plans had a section that covered people's communication. However, there was no individualised plan to support people's understanding. People's care plans or other information were not provided in

picture assisted or easy read formats.
• There were no tailored visual or other supports to enable people's understanding. For example, one person required regular engagement in activities to reduce anxiety or distress. A staff member said, "It can be quite difficult as [person] may only do an activity for a very short time." They would have benefited from visual supports, such as prompt cards which would enable them to make decisions about alternative activities.
• Information in relation to a person who understood and used Makaton signs was limited. Makaton is a signing language that is sometimes used by people with learning disabilities and autism. We observed one staff member using signs with the person, but this was not the case with other staff who were providing one-to-one support. Staff had not received training in Makaton, and there was no record in the person's care plans indicating the Makaton signs they understood.

The failure to ensure people received care and support in line with their needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• We were told no complaints had been received in the last 12 months. The service had a complaints policy and procedure. A family member told us they had no complaints about the support their relative received.

End of life care and support
• The service was not providing end of life care. Procedures were in place to support people if and of life support was required.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The provider had failed to ensure people's views were fully addressed. Although the service had made efforts to engage with people via meetings and surveys, there was no evidence of evaluation or follow-up activities in relation to responses.

• Outcomes of people's care plans and behavioural monitoring had not been evaluated to identify if improvements had been achieved.

• People with specific communication needs had not been provided with alternative communication methods to support their understanding.

• The service had failed to fully record and monitor people's behaviours to identify patterns, triggers and causes. Managers and staff had not received recent training in behavioural management and support. This meant there was limited understanding of the communication function of behaviours considered to be challenging, and we did not see information in people's care records that would demonstrate such understanding.

• All this meant the service was at risk of creating a 'closed culture'. This is a poor culture that can lead to harm, including human rights breaches such as abuse. The absence of supports to evaluate and understand people's behaviours and to facilitate participation meant people were not being fully supported in accordance with the Regulations of the Health and Social Act 2018 (Regulated Activities) and Right support, right care, right culture, which is statutory guidance for service supporting people with learning disabilities and autism issued by CQC. We expect providers of learning disabilities services to have regard to this, in order to maximise choice, control and independence of people using their services. Although we saw no evidence of human rights breaches or abuse during our inspection, there was no evidence of actions by the provider to reduce any potential risk of these occurring.

This demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us they felt they received the information and support they required to undertake their roles. However, they had not been provided with all the training they required to meet people's assessed needs.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

• The service had carried out quality assurance processes but these were limited and had failed to identify gaps or failures.
• Environmental audits and risk assessments had been carried out by the service. However, these had failed to identify and act on safety concerns, such as hot water temperature monitoring and issues in relation to fire safety.
• The provider had no system for evaluating the quality of people's care records or the outcomes of the care people received. Monthly reviews of people's care plans had not taken place since July 2021. There had been no evaluation of a person's behavioural chart. People's care plans and risk assessments did not include information and guidance about supporting needs such as epilepsy and diabetes. There was no evaluation of incidents or actions put in place to prevent the occurrence of similar incidents happening in the future.

This demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
• Although the service engaged with other professionals in supporting people's needs, this was not always consistently applied. For example, two people attended appointments with local specialists. However, we saw a referral to a specialist team had been closed due to a failure of the service to provide requested information.
• The service's records in relation to positive behavioural support plan referred to in a person's care plan and their medical records did not show if this had been followed. Another person's care plan and records had not been updated to reflect a request by a specialist to monitor their health condition had not been followed. This meant the service had failed to follow guidance provided by specialist health professionals.

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 provider understood their responsibilities in relation to duty of candour. Duty of candour requires that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment.

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 Regulation 9 Person centred care 1 2 3 (a) (b) (c) (d) The provider had failed to ensure people's care assessments, plans and records were reflective of people's identified needs and were monitored and updated as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 Need for consent 1. The provider had failed to follow guidance associated with the Mental Capacity Act 2005, notably in relation to demonstrating least restrictive alternative best interest processes used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 Safe care and treatment 1,2 (a) (b) (d) (g) The provider had failed to carry out risk assessments in relation to people's needs, or to monitor and review identified risks. The provider had failed to identify and mitigate risks associated with the care home environment. The provider had failed to safely manage medicines for people requiring PRN (as required) medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 Good governance 1 2 (a) (b) (c) (f) The provider had failed to monitor and evaluate issues in relation to the care and safety of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 Staffing 1,2 (a) (b) The provider had failed to ensure that all staff had received regular mandatory training and receive regular periodic supervision. The provider had failed to ensure staff were provided with training in relation to people's specific care and support needs.