The Disabilities Trust

The Maples

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Maples is a care home without nursing for up to 15 people aged 18-65 years of age living with a range of complex conditions, including autism with associated sensory and communication difficulties, and complex behavioural needs. There were 13 people being supported in three different bungalows on one site at the time of the inspection.

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 that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

People's experience of using this service and what we found
The service could not show how they met the principles of Right support, right care, right culture.

Right support:
● The model of care and setting did not maximise people's choice, control and independence. The remote rural location of the campus meant people had to use a car or public transport to access local amenities. Due to vehicle sharing and 13 staff out of 76 who were authorised to drive, people could not always enjoy unplanned outings unless they utilised public transport. We received feedback that some staff did not feel confident to support people in the community, which also limited the use of public transport as an option for some people. One person told us, "We have no activity room now as they have turned it into a meeting room.". The provider told us there were plans to build a bespoke activity centre on site this year.

Right care:
● The care people received was not always person-centred and did not always promote people's dignity, privacy and human rights. People were not always supported by trained, skilled staff who were familiar with people's needs and agreed care plans. Agency staff, who were frequently allocated as people's one to one support, had not always received training such as, epilepsy or certified restrictive practice training. The provider had not reviewed the compatibility of people using the service or the impact of people's needs upon others' rights. A person told us they were frightened by one of the people they shared a house with.

Right culture:
● During our inspection the management team were open about the need to make improvements and had started to invest to develop the service. However, at the time of our inspection, this had not made enough impact to enable people to live full, inclusive or empowered lives. Staff told us they felt there was a lack of visible leadership, and management failed to act on known issues. For example, alarm technology to manage risk was not being implemented by staff due to lost equipment. The management team had not

acted to replace equipment or seek suitable alternatives.

People were not 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 did not support this practice.

● People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs. People's homes were in a state of disrepair and did not provide a good standard of comfort or therapeutic surroundings for people with different sensory needs. We were not assured that the provider had consistently implemented effective infection control systems to ensure people and others were protected from the risks associated with COVID-19.

● People were not protected from abuse and poor care. Staff were not always able to recognise or respond appropriately to abuse. For example, staff did not recognise the unauthorised use of restrictive physical interventions were a potential form of abuse. The service relied on a significant amount of agency staff which impacted on people's care. Care staff, both permanent and temporary, had not always been provided with training or had their competency assessed to ensure they had the skills to safely manage behaviours that could challenge the person and others.

● People did not receive care, support and treatment from trained staff and specialists able to meet their needs and wishes. The provider had not ensured that staff had relevant training, regular supervision and appraisal.

● People were not always supported to be independent and have control over their own lives. Their human rights were not always upheld. The provider had not ensured all staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.

● People did not always have care from staff that protected and respected their privacy and dignity and understood each person's individual needs. People's communication needs were not always met, and information shared in a way that could be understood.

● People's risks were not always assessed regularly in a person-centred way. People were not involved with managing their own risks whenever possible.

● People who had behaviours that could challenge themselves or others had proactive plans in place to reduce the need for restrictive practices. However, there was limited evidence of this guidance being followed by staff. Systems in place to report and learn from incidents where restrictive practices were used were not effective.

● People did not always make choices and take part in meaningful activities which were part of their planned care and support. People's aspirations and goals were not fully explored so staff could support them to achieve these. Support did not focus on people's quality of life and follow best practice.

● People's care, treatment and support plans, did not fully reflect all of their sensory, cognitive and functioning needs. People and those important to them, were not actively involved in planning their care. Care plans were not always reviewed to ensure they were up to date and accurate.

● Systems were not fully embedded to ensure the safe management of medicines. The provider was working to their own medicines improvement plan. However, this had not identified or mitigated all the concerns we found during the inspection.

● Referrals to appropriate health professionals had not always taken place, and when they had, not all had been followed up to ensure actions were taken to improve people's health and wellbeing.

● People were not always supported by staff who understand best practice in relation to learning disabilities and autism. The provider was aware of the shortfalls in staff knowledge and training and was taking steps to improve staff training and support in these areas. Governance systems did not ensure people were kept safe

and received a high quality of care and support in line with their personal needs. People and those important to them, were not fully involved with leaders to develop and improve the service.
● Where people were supported by staff who knew them well, and understood the support they required, people experienced caring and positive relationships with staff.

The provider recognised improvements were required and had reacted with an action plan. However, there was not a clear understanding of risk-based priorities or vision shared by the whole team to drive improvements. We asked the provider for reassurance that they would take urgent action in response to our findings on the first day of the inspection. We checked that this had taken place on our second visit.

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

Rating at last inspection
The last rating for this service was Good (published 4 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about safe management of medicines. A decision was made to undertake a comprehensive inspection to provide assurance that the service is applying the principles of Right support right care right culture.

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 Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Maples 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 identified eight breaches at this inspection in relation to person centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse, premises and equipment, receiving and acting on complaints and good governance and staffing.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the relevant local authorities to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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 act 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 effective.

Details are in our effective findings below.

Inadequate

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 responsive

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well led

Details are in our well led findings below.

Inadequate

The Maples

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
Four inspectors and an Expert by Experience visited the service on the first day of 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. On the second visit three inspectors attended the site and the Expert by Experience made telephone calls to relatives.

Service and service type
The Maples 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 although they were not in day-to-day control of the home at the time of this inspection. This means that they and the registered provider are legally responsible for how the service is run and for the quality and safety of the care provided. A manager was newly in post. We refer to them as the 'manager' in this report.

Notice of inspection
The inspection on both days was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last 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 observed care and support throughout the inspection visits to help us understand the experience of people who could not talk with us. We spoke with five people who used the service. Other people were not able to verbally communicate with us, so we observed their interactions with staff members throughout the inspection. A member of the inspection team was able to assist people's communication with some use of Makaton. Makaton is a communication method that uses symbols, signs and speech to enable people to communicate. We spoke with 18 members of staff including the regional project manager, quality assurance business partner, business administrator, service manager, assistant manager, two team leaders, 11 support workers including one bank and two agency staff members.

We reviewed a range of records. This included 10 people's care records including six people's medicines records and five medicine related care plans. We looked at two staff files in relation to recruitment and staff supervision and agency staff files and processes. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with nine relatives by telephone to seek their opinion about their experience of the care provided. We sought feedback from local authorities who commissioned people's support at The Maples. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Following the inspection, we discussed our initial findings with the management team at The Maples including the Nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

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

- People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment. We found multiple areas of concern. For example, damage to fixtures and fittings in a person's bedroom posed a high risk of harm and injury to the person.
- We were not assured that the provider was preventing visitors from catching and spreading infections. For example, during the inspection we saw staff were not always wearing protective or appropriate masks in the correct way at all times to ensure they protected themselves and others from the risk of infection.
- People were not always involved in managing their own risks whenever possible. The provider had not ensured risks were anticipated and managed in a person-centred way. We did not see a culture of positive risk taking.
- Risks had not always been anticipated or managed. There was no risk assessment to reduce the risk of choking for one person and staff had not signed another person's epilepsy plan to agree they were aware and would follow the guidance. Staff we spoke with were not always familiar with people's emergency epilepsy protocols.
- Staff did not always have a high degree of understanding of people's needs. People were not always supported by staff who provided care and support in line with people's care plans. Not all staff were trained in authorised physical interventions to maintain everyone's safety in a crisis. During our visit staff gave us advice about how to interact with a person if they approached us, which went directly against their agreed care plan. This put people, staff and others at risk of harm.
- People's care records were not easily accessible to staff, with complete and up to date information. There was not a robust system, such as a quick reference guide, to ensure key information was accurate, up to date and readily available for staff to refer to if needed at the start of each shift.
- Staff did not maintain high quality care records. Entries on people's daily records were sparse, difficult to read and did not reflect people's planned care to show it was fully delivered.

We found no evidence that people had been harmed however, the provider had failed to ensure that systems in place were robust enough to ensure risks to people were managed safely. This included ensuring premises were kept clean, fit for purpose and free from infection. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we were informed a cleaning schedule had been introduced and housekeeping hours increased to ensure people's environments were kept clean and infection free.

Staffing and recruitment

- People were not always kept safe from avoidable harm. The service did not always have staff who knew people and had received relevant training to keep them safe. The service did not regularly review staff skills to ensure they were able to meet people's needs competently.

We found no evidence that people had been harmed, however, the provider had failed to ensure that staff had the skills, competency and experience to ensure people were kept safe. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had recruitment processes in place. Pre-employment checks were completed for staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check.

Using medicines safely
● Staff did not always follow systems and processes to safely order, receive, administer, record and store medicines. On the first day of the inspection we had concerns about medicines storage. There were standard operating procedures and policy in place for medicines management. However, staff did not always follow them. For example, we found staff did not carry out regular stock checks for controlled drugs as per the provider's policy
● People were not always assured of receiving the correct medicines at the right time. Some people at the home were prescribed emergency rescue medicines to manage their seizures in an emergency. Access to these medicines was not available to staff in a timely manner due to where they were stored.
● The staff at the home were aware of STOMP (stopping over-medication of people with a learning disability, autism or both). However, systems in place were not always used by the staff to effectively monitor the use of medicines in relation to STOMP. STOMP was established to ensure people's behaviour was not controlled by excessive or inappropriate use of medicines. The provider's incident report did not include information such as assessing a response to medicines and any side effects. For example, one incident report documented that a medicine was suggested but did not confirm if it was administered. A relative said, "We're keeping an eye on his medication. We are a little bit concerned – who decides when he needs it? Is it anyone? Or specially trained staff. Who? We can bring it up at his annual review."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure medicines were managed effectively. This was a further breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had developed an action plan to review the medicines systems and provide training and guidance. This was being led by an internal quality assurance business partner who was also a registered nurse. There was a process in place to report and investigate medicines related errors and incidents.
● People's medicines were reviewed by health professionals to monitor the effects of medicines on their health and wellbeing.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always safe from abuse. Staff were not always able to recognise or respond appropriately to abuse. During our inspection we observed a person's behaviour of concern encroached upon other people's human rights. We saw one person expressed their concern and told the person to stop. Another person told us they felt frightened by the person's behaviour. Staff told us and records confirmed, incidents impacted upon other people who lived there. For example, on one occasion a person had to exit their own private space and on another all other people had to evacuate their home to maintain their safety.
●The service did not record all crucial information for incidents where people's behaviours could challenge themselves or others including where restrictive interventions were used. For example, incident reviews failed to scrutinise whether staff responses to a person's distress and behaviours that challenged, were in accordance with their agreed care plans. Debriefs were not always offered to both the person involved and their staff team.

● People were not always kept safe as managers had not maintained people's safety by investigating accidents and incidents to monitor for trends and patterns. Therefore, these were not shared with the staff team to ensure lessons were learnt to improve safety.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure people were safe from the risk of abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We had mixed reviews when seeking feedback from relatives about whether people in the service were kept safe. One relative said, " They've kept him safe through this terrible crisis, I feel grateful for that."

Inadequate

Is the service effective?

Our findings

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet and Staff working with other agencies to provide consistent, effective, timely care

- Not all people's care and support needs had been consistently assessed in order to refer to professionals for support. For example, one person had not been referred to their GP or swallowing specialist for assessment where concerns had been noted about a risk of choking. The management team took action to refer the person for an assessment in response to our concerns.
- Care and support plans did not fully reflect people's needs and aspirations. People, and those important to them had not been involved in developing individualised care and support plans which were based on people's strengths and showed all their care and support needs.
- Where people had a sensory assessment, this was not reflected in the décor of their rooms. For example, one person's sensory assessment said the person liked bright colours, but this was not apparent in their room. Some people's bedrooms were personalised; however, we saw other rooms were sparse, and not personalised. The decoration of communal areas of the buildings gave a clinical feel throughout. A member of staff who was showing us around was unsure which people lived in each room.
- People's needs were not always regularly reviewed and where reviews had taken place, other parts of the person's care plan had not been updated to reflect changes in need. For example, updated safety plans in relation to crisis interventions for one person were not referred to in their positive behaviour support plan.
- We asked the management team whether there had been a review of the suitability of the environment or the compatibility of people living in the home; they were not aware of this and told us they would take action to do so.
- People were not always supported to access physical healthcare to lead healthier lives. Records were not always updated to reflect professional guidance was sought, provided and actions taken as a result. For example, one person's health action plan documented a visit to the dentist in March 2018 with an instruction to book a follow-up appoint for September 2018, however, the next appointment recorded was not until November 2020. There was no evidence of any follow-up reviews and this information was not included within their care plan for staff to be aware of.
- Staff told us the podiatrist stopped visiting the service due to COVID-19. A relative said, "Oh dear [person's] care has been poor. When he came home the first time after lockdown, I cried looking at his feet and hands, no proper care. I consulted with the GP who prescribed appropriate medicines. He has 15 hours of one to one care. Didn't anyone see his feet? I wasn't going to send him back until the condition had improved. Before lockdown he was coming to us so we could take care of him. I hope it won't deteriorate further." The provider had not taken timely action to ensure suitable alternatives were implemented in the absence of podiatry.
- The service did not consistently use a screening tool for malnutrition. People's weight charts were not consistently completed. One person's weight had fluctuated up and down but there was no indication of

what action had been taken in response to a significant weight loss reading.

We found no evidence that people had been harmed, however, the provider had failed to enable and support people to access health care professionals where appropriate. This is a breach of regulation 9 (Person centred care) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

● People had access to plenty of fresh fruit and vegetables. Cupboards and fridges contained a variety of food groups and snacks. Staff supported people to choose and purchase their own groceries.

Staff support: induction, training, skills and experience
● People did not receive support from staff who had received relevant training in order to ensure people's human rights were maintained and interventions used in the least restrictive manner. Although staff had received training in autism, competency was not assessed to see if the quality and appropriateness of training was effective and being delivered to meet people's assessments and care plans.
● The service had not implemented processes to monitor staff performance, provide feedback or listen to staff concerns. Staff told us they had not had regular supervision, appraisal or team meetings and did not feel supported by the provider, a member of staff said, "[There is a] high turnover of staff because of lack of support. We need meetings to discuss what is not working. There is no confidentiality regarding staff issues. We need one to one supervision to discuss issues"
● The provider disputed that staff turn-over was high, rather that it was in line with the care sector average.

We found no evidence that people had been harmed, however, the provider had failed to ensure that staff had the skills, competency and experience to ensure people's assessed needs were met. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers provided an induction programme for any new or temporary staff. However, agency staff told us they did not receive specific training for individual people during their induction. Staff responsible for booking agency confirmed agency staff did not receive positive behaviour support or certified restrictive practice training.

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.

● People's human rights were not always upheld. People were not always supported to be independent and have control over their own lives. For example, a person told us they were upset because they had been told by the provider, they were only allowed one beer at the pub instead of their usual two. The member of staff supporting them did not know why this choice had been taken away from the person as they did not believe there were any risks.

● People were not always supported to make decisions about their care. For people that the service assessed as lacking mental capacity for certain decisions, financial and medication mental capacity assessments for two people had not been reviewed since 2017. There were no mental capacity assessments or best interest decision records for people's positive behaviours plans.

The failure to work within the principles of the MCA was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Restrictive interventions were not regularly monitored. Some people had DoLS in place with conditions that had to be adhered to, such as ensuring that MCA were in place for decision making around the person's care. We found those conditions had not been met. Up to date DoLS were applied for after some had expired. We found none of the conditions that had been present on the expired DoLs were not being monitored to ensure the least restrictive options were taken whilst awaiting authorisation from the supervisory bodies.
● Records did not evidence that restrictive practices were only used where people were a risk to themselves or others, used as a last resort, and for the shortest time possible.

The provider had failed to ensure it was acting lawfully when depriving people of their liberties whilst receiving care. This is a further breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

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

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Staff did not always protect and promote people's privacy and dignity. One person had put tissue paper up on some of the windows in their private room. They told us this was to prevent people from looking in. The provider had not considered adaptations to support the person or two other people in the service who may also benefit from more privacy.
- A staff member told us they were concerned people's right to privacy and keeping their personal belongings safe were not being upheld because one person liked to open the door to their private rooms and would enter on occasion. The person's care plan did not address how staff should respond if people denied the person access.

The provider had failed to ensure people's dignity, respect, autonomy and independence were promoted. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The care people received was not always person-centred and promoted people's dignity, privacy and human rights. Staff turnover and vacancies meant people were not always supported by trained, skilled staff who were familiar with people's needs and agreed care plans.
- We observed the majority of staff were caring towards people and generally people appeared relaxed in their company. Staff spoke about people with compassion, respect and concern for their welfare. A member of staff said, "I'm not much appreciated - all these guys are unique. I know [person] likes going for walks. You have to really know the individual. There's so many agency staff! – but they're good."
- We observed support workers playing a game with a person. The person looked happy and joined in with lots of laughter and started to sing a song with other staff joining in. Another person approached the group with their support worker and was warmly acknowledged by everyone.
- Staff supported people to maintain links with those that were important to them. A relative said, "In general, we're pretty pleased with the care received, particularly the last 1½ years with the lockdown."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we recommended the provider refer to best practice guidance, on delivering care and support to meet people's assessed needs to achieve meaningful outcomes. This was in relation to ensuring people's care was delivered in line with their care plans such as accessing social activities due to the location of the service. The provider had not made enough improvements. The provider told us improvements to increased social activities were made but were not sustained due to COVID-19 restrictions.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 service did not always work in a person-centred way to meet the needs of people with a learning disability and autistic people. The practice and the principles of Right support, right care, right culture was not fully carried out.
- Support did not focus on people's quality of life outcomes or meet best practice. We saw some information about what activities people had chosen to take part in, however, there was limited evidence of people being involved in care planning to develop meaningful goals in line with their interests and preferences.
- There was limited evidence that support was provided in line with people's care plans including communication plans, sensory assessment and positive behaviour support plans. There was limited evidence that all staff had read people's care plans to ensure these were followed. People were often supported by staff that didn't know their needs and preferences well.
- There was limited evidence that people had access to a range of meaningful activities in line with their personal preferences or chose the activities they took part in. People's daily records had minimal records of what activities people had taken part in. During our inspection one person did not get out of bed until after 2pm. Daily records by staff stated the person spent most of the time "relaxing in their flat". We saw the same information on most days such as walk, drive, shops or lunch out. Their care plan stated staff should encourage them to get out of bed by 10am to attend their preferred activities such as swimming and trampolining but there was no evidence of other activities explored when these were stopped during the COVID-19 pandemic.

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 not always met. People's communication needs were assessed, however, systems put in place were not being used consistently by staff. For example, a positive behaviour specialist described in their assessment that a person had a communication board with visual aids and an

activity planner. We asked about the use of these and were told they were not being used. This meant people's ability to communicate was compromised as their preferred methods were not being used.
● People did not have access to all information in appropriate formats.

The provider had failed to ensure people's care was appropriate, met their needs and reflected their preferences. This is a breach of regulation 9 (Person centred care) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

● Other people appeared to be engaged by the staff supporting them in daily living and various activities in the community. For example, one person went for a walk and picnic, another person browsed charity shops which staff told us was one of their favourite activities. Another person was supported to go to the pub and in physical activities such as digging a hole in the woods as they enjoyed this. A relative said, "[Person] and their key worker go 'fossil hunting'. [Person] bought some stuff from the hole back home to show us this time. He really enjoys it, they have loads of fun together."
● Relatives felt the provider had done enough to enable people to keep in contact with loved ones during the COVID-19 pandemic. Relatives comments included; "Hats off to the guys there, they've done such an amazing job especially with lockdown. The previous assistant manager came up with the idea to use facetime and put in an order to get everyone tablets. It was brilliant."

Improving care quality in response to complaints or concerns
● We saw where people had raised a complaint with staff support there was no record of the outcome and what action had been taken to resolve the issues raised. Staff told us they supported a person to write a letter of complaint last year about how another person living in the service made them feel frightened. The staff member was not aware of the outcome. We asked the management team to provide evidence of how this was dealt with in line with their complaints policy and procedure. This was not provided, and we did not receive any explanation.
● After our inspection the provider told us they did not have a record of this complaint and were not aware of it until we brought it to their attention.

The provider had failed to ensure all complaints were investigated and evidenced that necessary action had taken place. This is a breach of regulation 16 (Receiving and acting on complaints) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

● A relative said, "I know who to complain to – I go right to the top. I contacted the Disability Trust about home visits. We're double vaccinated and so is [person]. They were being too health and safety and overly careful. I do understand the need to be careful. I received a good and fast response and they immediately reviewed their processes and indeed he now comes home."

End of life care and support
● At this inspection no one was receiving end of life care. Should someone require end of life care, the manager and the provider would work with the placing authority to see if they were able to meet such needs.

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.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Our findings from the other key questions showed that governance processes had not ensured people were kept safe, their human rights protected, and that good quality care and support was provided.
- The provider had failed to monitor and improve the culture of the service. Care was not person centred and people were not always cared for in a safe way. The environment did not show full reflection and respect for people's individual choices. We found the principles of Right support; right care and right culture had not been evidenced during this inspection, including supporting people to express their views and respecting privacy, dignity and independence. People's homes were in a state of disrepair and did not provide a good standard of comfort or therapeutic surroundings for people with different sensory needs.
- Staff had mixed feelings about the support they received from the management team. Some staff said they felt supported and hopeful with the new management in place. In contrast other staff said there was a lack of communication and consistency from management.
- Leaders did not always demonstrate the values and vision as stated in the provider's policies to fully enable people to live full, inclusive or empowered lives. Leaders were not always visible in the service and approachable for people and staff. Staff told us they had raised concerns, but that management did not always act on known issues. One commented, "I feel our aim is to increase people's independence. The assistant manager is not approachable and always says 'I'm busy, I'm busy'. We used to have a manager who came every morning to see all the people here and she really knew them. The assistant manager doesn't know people and won't visit their rooms. The management attitude is bad. I think this place has so much potential, but they're obsessed with paperwork, there should be a balance."
- Not all staff and relatives had been introduced to the new manager. A relative said, "It's been very good apart from the management changes. It's affected us because we knew them so well, we got to know them, and they knew [person] so well too. The new manager we haven't heard from. Apparently, she is going to be in contact with us. We've met assistant manager. They need to get used to [person] as likes routine, so this is important, and changes are not good."
- Staff did not always feel respected, supported and valued. One commented, "The team leaders and management need to listen more. We know people more and they should not make decisions without consulting us".
- We did not see that people, and those important to them, worked with managers and staff to develop and improve the service. We did not see how feedback was sought from people and those important to them and used to develop the service.
- Staff did not always have the information they needed to provide safe and effective care. Records of care and support were disorganised, inaccurate or out of date. Daily records which had brief details of

behaviours of concern, had been filed away with no review or auditing to identify if people had received the care, support and outcomes they required. Staff members had not signed appropriate records in place to confirm they had read the care plans and understood the needs of the people living at the home.

● The provider had failed to submit notifications of certain incidents to CQC, which they are legally required to do. For example, we were not informed about concerns around management of medicines and were notified via the local authority.

● The provider had an improvement plan, however, this had not identified all of the concerns we found during our inspection and was not successful in sustaining compliance with regulations. During the inspection we found multiple breaches of regulation. These failings demonstrated the systems to assess, monitor and improve the service were not sufficiently robust.

Systems and processes had not been established and operated effectively to ensure compliance with all regulations. This meant the quality and safety of the service was inadequate as evidenced by the findings of this inspection. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with demonstrated they knew and understood the provider's vision and values and how to apply them in the work of their team. They showed a commitment to the service and told us they wanted to make improvements.

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 area manager told us there were no copies of correspondence as no circumstances had required action under the duty of candour regulation.

● Throughout the inspection the management team were honest and open with us. They acknowledged the shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

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 had failed to ensure people received care that was person-centred and met their needs.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were always treated with dignity and respect.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people were always treated with dignity and respect.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured adequate risk management to ensure people were protected from the risk of harm

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were

progressing with improving the service.

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 had not ensured that people were always protected from the risk of abuse and neglect.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that all complaints had been investigated and necessary action taken in response.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems and processes in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service.

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 were effectively trained and had the competencies, skills and experience necessary for the work they performed.

The enforcement action we took:

We imposed a condition on the provider's registration to regularly inform the CQC how they were progressing with improving the service.