Wingreach Limited

Throwleigh Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Throwleigh Lodge is a care home providing support to up to 17 adults with learning disabilities, mental health support needs and complex healthcare needs which require support from trained nurses. At the time of our inspection 15 people were living at the service. The service provided bedrooms and communal areas over the ground floor and first floor of an adapted building.

People's experience of using this service and what we found
Risks to people's safety and well-being were not always monitored and accident and incidents were not used to ensure improvements were made to people's care. The service was not cleaned to a satisfactory standard and safe infection control processes were not consistently followed. In addition to providing care, staff were required to undertake tasks including cleaning and laundry. This meant they did not always have time to spend with people socially.

People's care was not always person-centred and there was a lack of opportunity for people to be involved in planning their care. Communication plans lacked detail and did not provide guidance to staff on how to support people's communication needs. Activities were repetitive with little opportunity for people to access community activities. Some people benefited from weekly visits from the local church and a local charity providing communication sessions.

There was a lack of management oversight of the service. Despite previous concerns being highlighted, action had not been taken to improve the service. Quality assurance processes had not identified concerns regarding people's care and staff did not feel listened to or supported.

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support: The model of care did not maximise people's choice, control and independence. The service was larger than most domestic style properties and adaptations to how people's support was provided had not been made to minimise the impact of this.

Right care: The support people received was not always person-centred and did not maximise people's choices and opportunities. People were not always supported safely

Right culture: There was a task focussed culture within the service. The views of people, their relatives and

staff were not always sought and responded to.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (10 March 2020) and there were two breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 24 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Throwleigh Lodge 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 have identified breaches in relation to the safety of the care people receive, staff deployment, safeguarding, person-centred care and the management of the service at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our well-Led findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Throwleigh Lodge

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 was carried out by three inspectors.

Service and service type
Throwleigh Lodge 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 did not have a manager registered with the Care Quality Commission (CQC). A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The regional manager was overseeing the service at the time of our inspection.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 who used the service about their experience of the care provided. We spoke with nine staff members including the regional manager, senior clinical lead, deputy manager and care staff. We reviewed a range of records which included eight people's care records, accident and incident monitoring and complaints records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with six relatives who had regular contact with the service to gain their views.

Inadequate

Is the service safe?

Our findings

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

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

Preventing and controlling infection

At our inspections in October 2018 and January 2020 we found the provider had failed to ensure safe infection prevention and control systems were in place. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 for a third time.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the service were dirty and unhygienic. Examples of this included spots of black mould and dirt in the upstairs shower tray. The communal bathroom was dirty and cluttered with unused equipment. The arms of a number of lounge chairs were black with dirt. Although hand gel dispensers were placed around the service, we did not observe staff using these regularly.
● The cleaning schedule lacked detailed guidance for staff in how to reduce the risks associated with Covid-19. The types of cleaning materials to be used for which tasks were not listed, tasks were not specific and the manager sign off was not consistently completed. This increased the risk of infection transmission.
● The regional manager told us they had experienced difficulty in recruiting a housekeeper for the service but had now appointed to the role. However, it was not clear how hygiene standards expected of a nursing home would be met by one housekeeper working across the week.
● We were not assured the provider was making sure infection outbreaks could be effectively prevented or managed. Systems in place had not been monitored to ensure they would be effective in the event of an infection outbreak. An infection control checklist had been completed the week before our visit. However, this failed to identify the issues with cleanliness and hygiene practices.
● We were not assured that the provider was using PPE effectively and safely. One staff member was observed wearing gloves to support a person with their drink. The staff member then went on to support another person with their personal care whilst still wearing the same gloves. The same staff member left the room wearing gloves and walked into a communal hallway. Staff told us there was no supply of gloves in the person's room and we found no evidence in the person's room that the staff member had changed their gloves.
● The room used to store PPE was dirty and used for a variety of purposes including as an entry and exit point for staff and some visitors.
● Following our first day of inspection we wrote to the provider asking them to provide assurances of the urgent action they intended to take to address these concerns. On the second day of our inspection we

found steps had been taken to address issues regarding cleanliness and infection prevention and control standards. An action plan was also forwarded to clarify any additional work going forward. We will monitor the effectiveness of these measures at our next inspection.

We have also signposted the provider to resources to develop their approach.

The failure to maintain adequate standards of infection prevention and control was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was accessing testing for people using the service and staff.

Learning lessons when things go wrong

At our inspections in October 2018 and January 2020 we found the provider had failed to implement robust procedures to monitor accidents and incidents. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 for the third time.

- Accidents and incidents were not effectively monitored to minimise the risk of them happening again. We observed staff found it difficult to support one person with their anxieties. Incidents had not been consistently recorded to identify triggers to the person's anxieties, specific communication needs, and how staff should support them. This meant the person's anxieties and behaviours continued to have a significant impact not only on their well-being but on how others were able to access communal areas of their home. We observed the person threatening and shouting at both other people and staff. Staff told us as these incidents occurred frequently which made it difficult for others to access the lounge area safely. Following our inspection, the service forwarded a copy of the person's positive behaviour support plan completed in September 2020. However, staff we spoke with told us they did not know how to support the person effectively. The person's positive behaviour support plan had not been available during our inspection.
- The review of accidents and incidents did not always result in improvements in the way people received their care and how this was recorded. Where incidents had resulted in injuries such as skin tears or bruising, body maps were not always completed and incident forms did not identify the exact location, a full description of the injury or what treatment was provided. The provider could not be assured that appropriate care was provided to people following accidents and incidents.
- Accidents and incident reports were not always reviewed by a senior manager in a timely manner. The provider's IT system allowed for senior managers both within the service and in head office to review accident and incident records at any time. Despite this, we found that some reports had not been signed off for over two weeks. This meant there was a risk action required would not be taken in a timely manner. For example, records showed one person had an unexplained bruise. The regional manager told us they were unaware of this or what action had been taken.

The failure to ensure accidents and incidents were effectively acted upon was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Not all staff were aware of their responsibilities in relation to fire safety. During the first day of our inspection we spoke with three staff who did not know what action they should take when the fire alarm sounded. They were unable to tell us where the nearest evacuation point was or the relevance of the fire zones in the property. Staff told us they had not received this information as part of their induction into the service.

● Information on the support people required to evacuate the building in the event of an emergency could not be found on the first day of our inspection. The regional manager told us there was a grab file containing personal emergency evacuation plans (PEEP's) but neither they nor the staff members on duty were able to locate it. Although the file had been found on the second day of our inspection, this was disorganised making it difficult to find information. This meant neither staff nor the emergency services would have quick access to the information required to support people to exit the building safely in an emergency.

● The regional manager provided a list of the PEEP's in place. However, this had not been reviewed since March 2020 and did not consider any changes in people's needs or those who had moved in since this date.

● Due to the seriousness of these concerns, we requested urgent assurances from the provider regarding how these issues would be addressed. An action plan was forwarded and staff spoken to on the second day of our inspection had received training and guidance on fire procedures. We will continue to monitor this area of concern and seek assurances that systems have been embedded into practice.

● One person's health issues and behaviours presented potential risks both to themselves and others. Despite these concerns, staff supporting the person were not always fully aware of these risks and how they should be mitigated. These concerns had not been risk assessed as part of the person's overall assessment process. Guidance from previous agencies was noted on scraps of paper rather than within support plans and risk assessments. There was limited guidance for staff about how they should minimise risks or respond to the person's anxieties. The service had not approached external professionals for support in meeting the person's needs although had recently accepted support when offered.

● Systems to monitor people's health and well-being were not embedded into practice. Where people experienced falls or had banged their head, no post falls monitoring was completed to look for signs of injury or pain or to assess potential signs of serious head injury. This was of particular concern as many people living at Throwleigh Lodge would be unable to verbally communicate they were in pain. The nursing staff we spoke with were not aware of where post falls monitoring forms could be accessed or stored.

● Risk assessments in relation to people's skin integrity were not regularly reviewed or monitored. Where people required regular support to minimise the risk of their skin breaking down this was not always provided in line with guidance. Where people's risk assessments stated they should receive support to reposition at specified intervals there were no records to evidence this had happened consistently.

● One person was receiving support from the Tissue Viability Nurse (TVN) due to pressure sores which were not fully healing. The TVN had recommended staff support the person to walk for 10 minutes every hour. Staff supporting the person told us they were not aware of this guidance and there was no evidence to show this guidance being followed.

● Wound care plans were not implemented where people were experiencing pressure sores or skin tears. There was no description of the wound and no photographs taken to monitor progress. The type of dressings or creams used were not recorded and information regarding how frequently the wound should be reviewed was not noted. Daily records contained some limited information regarding monitoring although on occasions the records were conflicting.

● We spoke to the regional manager about the monitoring of risks and how they were managed. They told us, "Monitoring has fallen by the wayside. If you can't find it you're not looking in the wrong place, it's just not there." They told us they had recently raised concerns regarding the lack of health monitoring. This had been reported to safeguarding and the service had completed an investigation. However, this had been limited to specific areas which did not include the above concerns.

The lack of accurate and complete records in relation to people's health risks and how to manage people's needs safely was of particular concern as Throwleigh Lodge was staffed by a high proportion of agency staff who may be less familiar with people's needs.

The failure to ensure risks to people's safety and well-being were effectively assessed and acted upon was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff told us they did not feel there was sufficient staff available to meet people's needs. One staff member told us, "There's not enough staff unfortunately so their (people's) distressed behaviour has increased." A second staff member told us, "People are in their rooms a lot nowadays because of lack of staff."

● In addition to supporting people's care, staff were also required to complete a range of other tasks including cleaning throughout the building and laundry. We observed these tasks took staff away from their main role and meant they did not have time to spend with people socially. One staff member told us, "We can't do everything. We want to be here for the residents but there isn't the time."

● People were not always supported by staff who knew them well. A large number of agency staff were deployed within the service which meant additional pressure was put on permanent staff members. The regional manager and senior clinical lead told us agency staff were blocked booked to establish a level of continuity for people. However, staff told us that whilst they appreciated the support of agency staff, they needed to take time to show them what to do. One staff member told us, "At the moment there's so much agency and it's really hard as they don't know the people."

● Staff told us that since our last inspection one person's one to one funding had been withdrawn. They said this had a negative impact on the person's well-being and they had become more withdrawn. The regional manager told us the person's one to one was still in place and should be provided by the existing staffing compliment rather than allocating an additional staff member. However, staff told us this was not possible alongside their other responsibilities. The person's one to one support was not highlighted on the rota to ensure a designated staff member to provide this care. Following our feedback, an additional staff member was rostered to provide the person's one to one. On the second day of our inspection we found the person was more engaged in their surroundings, smiling and taking part in activities they enjoyed.

The failure to ensure suitable and sufficient staff were deployed was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes were in place to help ensure staff were suitable for their roles. All candidates completed an application form and had a face to face interview. Once accepted, checks were completed such as obtaining references, proof of the right to work in the UK and a Disclosure and Barring Service check (DBS).

Systems and processes to safeguard people from the risk of abuse

● Relatives told us they felt their loved ones were safe living at Throwleigh Lodge. One relative told us, "I do feel he is very safe with the care and attention that he is given." A second relative told us, "I am positive he would tell me if he felt unsafe."

● Despite these comments we found staff had not reported concerns to external professionals. Staff told us they received safeguarding training and were able to describe reporting procedures. However, staff informed us of concerns regarding incidents of people experiencing verbal abuse from others living at Throwleigh Lodge and people not receiving their allocated care hours. They told us these concerns had been shared with the management team but no action had been taken. Neither the management team nor

staff had passed this information to the local authority safeguarding team as potential allegations of abuse or neglect. This meant the local authority were unable to act on these concerns to ensure people's safe care.

● We identified one safeguarding concern which had not been appropriately reported to the local authority safeguarding team. Staff reported one person had unexplained bruising to their wrist. The review of the incident form stated, '(Person) is known to grab harshly into staff during interaction. Staff to be more cautious and gentle.' The regional manager told us they were unaware of this incident. They reported the concern to the local safeguarding team following our inspection.

The failure to ensure safeguarding concerns were consistently reported was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found safeguarding concerns were reported in line with requirements. Where concerns had been raised regarding staff practice appropriate action had been taken to report these concerns. Where additional information was requested from the service this was provided and investigations had been completed.

At our inspections in January 2020 we found the provider had failed to ensure the adaptations and design of the home was person-centred. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● Communal hallways were in the process of being refurbished. This had created a more open and less institutionalised feel to the areas.
● Bathrooms had been refurbished. Adapted fixtures had been used which were in line with people's needs. The adaptations were completed on the second day of our inspection so we were unable to assess the impact this had on people's care. However, staff told us they felt this would make people's care more comfortable and pleasant for them.
● On the first day of our inspection we found the storage of equipment remained an issue. However, following the deep clean of the service this we found this had improved on our second day of inspection.

Using medicines safely
● Safe medicines processes were followed. The regional manager told us that concerns regarding medicines processes had been previously identified and addressed. This continued to be monitored and systems were working well.
● People received their medicines in line with their prescriptions. Each person had a medicines administration record in place which was fully completed. Staff were able to describe people's routines and how they liked to take their medicines.
● When administering medicines, staff took time to explain to people what was happening and checked medicines had been taken prior to signing to confirm they had been administered. Where people required their medicines at specific times staff were aware of this.
● Guidance was in place for people whose medication was administered as and when required (PRN). This described the reason for the medicine and described when this should be administered.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- We received mixed responses when asking relatives if they felt staff understood their loved ones' needs. One relative told us, "I feel the majority of them do (know their needs). I feel very confident that they are up to speed." A second relative said, "Most of them know but some seem to just come in and don't know what they are doing. They have no experience."
- Whilst individual staff members supported people with kindness, there was a lack of personalised care. The routines of the day were task focussed rather than people being at the centre of their care. For example, we observed the majority of people spent time in their rooms after lunch whilst staff were taking their breaks.
- People's care was not always reviewed regularly to ensure changes in individual needs and wishes were responded to promptly. One relative told us, "They used to do reviews but it's been a long time since the last one." The care records for six people we viewed did not contain evidence they or their family members had been involved in reviewing their care within the past year.
- People's needs were not always responded to promptly. One person required a new wheelchair for their comfort and to enable them to access the community more easily. Despite funding being in place since July 2020, no action had been taken to order the wheelchair. On the second day of our inspection we observed the person spent the majority of their day in their old wheelchair. Staff told us they were unable to support the person to their own comfortable chair in the lounge due to the behaviours of another person using that area. Following us raising these concerns with the regional manager action was taken and the person's new wheelchair purchased.
- In some areas developments were being made to personalise people's care. For example, one person wished to eat different types of food. Staff had begun to support the person to go to the shops once a week to purchase items of their choice. Whilst this plan had only recently been implemented it had a positive impact on the person.
- People's rooms were decorated in a personalised way. Individualised items such as photographs, posters and memorabilia were displayed which reflected people's interests and those who were important to them.

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 careers.

● People's communication plans lacked detail and did not always provide guidance for staff on how to support people's individual communication needs. One person's communication plan stated staff should use effective communication and encourage the person to make choices and decisions regarding their care. However, there was no guidance regarding how to support the person to do this.
● Where communication plans did contain guidance for staff, this was not always followed. One person's plan referred to the use of picture cards to aid the person's communication. The deputy manager said the cards were in the office and had not yet been introduced in practice. They told us, "We plan to introduce them as soon as things have started to settled down."
● People's communication styles were not always known to agency staff and care plans were not always accessible to agency staff. This meant people's choices and control may be limited. When engaging with one person they made a gesture which we did not understand. We asked the agency staff supporting the person what this meant but they were unable to tell us. The person's keyworker explained they were gesturing they wished to leave the dining table.
● The person's care plan stated a communication passport would be developed with the person. We asked the deputy manager where this was located. They told us, "To be honest, I have never seen one, so I do not think it exists." Staff who did not know the person well did not have guidance to refer to.
● Alternative communication methods had not been explored to support people's communication. The senior clinical lead told us they had developed a box of communication resources for staff to refer to. They told us, "The idea is staff can use them and assess people's communication needs going forward." The regional manager and senior clinical lead confirmed this had not been implemented to date.
● Systems were not in place to ensure people's care records were presented in way which was accessible to help them understand and contribute. Important information such as the complaints policy or safeguarding information was not displayed in a way which would help people know how to express they had concerns.
● Permanent staff were able to describe how people they were supporting expressed their basic emotions through body language and facial expressions. They were also able to describe some people's hand signals and actions and were aware of how to respond to them.

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
● We received mixed responses from relatives regarding how contact had been maintained during the Covid-19 pandemic. One relative told us the service had cancelled five video calls with their loved one which had left them upset. A second relative said, "They provided a gazebo for visits. They are preparing a room inside for visits. Zoom calls were supported every week."
● Staff told us they found it difficult to engage people in activities due to the lack of staff. One staff member told us, "People are in their rooms a lot nowadays because of lack of staff." A second staff member said, "It's been difficult recently as we need more staff, so at the moment we are not doing a lot of activities."
● Activities were repetitive and not always person-centred. We observed the same activities took place on both days of our inspection. These included colouring, board games, sitting with sensory items, watching television and listening to music. Staff told us these were the normal activities within the home. Staff were unable to describe what personalised activities people enjoyed or how they supported them to take part.
● At our last inspection in January 2020 we found the sensory room was used for storage so was not available to people. We found this was still the case during the first day of this inspection. One staff member told us, "It's become difficult with space and some behaviours. It means some residents have to stay in their rooms more." We raised these concerns with the regional manager. On the second day of our inspection the room had been cleared and deep cleaned ready for people to use.
● The service was working with external agencies to support people's interests. These included Us on a Bus, a visiting service providing interactive sessions to people with complex needs. However, there were no plans for staff to continue this type of activity with people who engaged well with this type of support.

End of life care and support

● There was limited information regarding the support people wanted at the end of their life. Whilst people had funeral plans in place, the service had not explored how and where the person wished to be cared for when nearing the end of their life. There was no record of who they wanted to be informed and involved. Consideration had not been given to things which would be important to the person as they approached the end of their life.

● At our last inspection in January 2020 the manager had assured us that improvements would be made and this was an ongoing piece of work with the people, and where appropriate their families. There was no evidence this work had been completed at the time of this inspection.

The failure to ensure people received person centred care was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy in place which set out how complaints could be raised, timescales for responses and how appeals would be processed.

● The regional manager told us no complaints had been received since our last inspection in January 2020.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

At our inspections in October 2018 and January 2020 we found the provider had failed to maintain accurate records and to seek and act on feedback from people and those acting on their behalf. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 for the third time.

● The service did not always communicate with relatives effectively. Relatives told us that whilst staff would inform them of concerns, it could be difficult to gain general information about their loved one. One relative told us, "They used to let me know everything but I don't feel that confident at the moment." A second relative said, "I ring a lot but they don't always answer the phone. They let me know if there's anything wrong."
● People were not engaged in the running of the service and were not supported to make choices about their home. No meetings were held with people to discuss how the service was run or changes they would like to make. On the first day of the inspection the upstairs hallway was being refurbished. We asked one person if they had been involved in choosing colours or carpets. They told us, "The staff do that. I'm not sure what it's going to be."
● Feedback from people and relatives was not sought in order to monitor and improve the service provided. Satisfaction surveys were not distributed in order to obtain feedback from people and their relatives regarding the service provided. Sections of the care planning process gave space to record people's views although these were not routinely completed.
● Staff told us they did not feel able to make suggestions and were not asked their opinions on how the service was run. One staff member told us, "That's a difficult one as there has been a lot of change with managers. We don't really get asked for feedback too much." A second staff member told us, "We used to try and speak up but they don't listen. Morale here is very bad."
● Staff meetings were not held regularly and did not support staff to look at possible solutions to their concerns. We requested copies of staff meeting minutes since our last inspection in January 2020. One set of minutes were forwarded from a staff meeting in October 2020. There was little information regarding the

support which would be available to staff to implement any suggested changes. For example, it was identified that staff lacked understanding of their role as a keyworker to individuals living at Throwleigh Lodge. Minutes showed managers discussed the broader aspects of the role although did not state how staff would be guided or trained in meeting these responsibilities.

● Accurate records of people's care were not maintained. The service had been using an electronic care planning and monitoring systems for nine months. However, there were significant gaps in records on the system and paper files were also still in use. The regional manager told us they had recently been informed there was also additional care records stored on a computer which the majority of staff were unable to access. This demonstrated the provider had not ensured staff were able look for information or guidance to ensure people received safe and responsive care. This was especially concerning given the high use of agency staff who may be less familiar with people needs and who relied upon accurate and complete care plans to safely support people.

● Records were disorganised and difficult to access. During our inspection we asked for a range of documents relating to people's care. Neither staff members nor the management team were able to access information requested easily. The regional manager told us staff's knowledge of the electronic recording system was limited and access to different elements of the system were restricted to certain groups of staff. They felt this had caused staff to stop recording monitoring checks, particularly in relation to people's health care. However, the management team had only recently identified this as a concern and systems to enable agency staff easy access to the system had not been established. They told us additional training for staff was being planned to address these concerns.

The failure to ensure maintain accurate records and to seek feedback from others was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

● Previous concerns had not been addressed to ensure people received safe and responsive care. Following our last inspections in October 2018 and January 2020 the provider had submitted comprehensive action plans to CQC to outline how they would address the concerns identified. However, the areas highlighted had not been addressed which meant people remained at risk.

● Following our first day of inspection we wrote to the provider expressing significant risk concerns regarding fire procedures, infection control practices, staffing and management over-sight. The provider responded positively and quickly to address these issues. However, they had failed to identify and address these concerns through their own proactively management processes.

● The provider had failed to ensure consistent and robust oversight of the service. This had led to risks not being effectively managed and had impacted on the quality of the care people received. The registered manager left the service in October 2020. The regional manager then took oversight of the service, basing themselves there for three to four days each week. However, during this time they were also supporting four other services within their regional manager role.

● During the time the regional manager was overseeing the service they identified a number of concerns regarding staff competence and conduct. Despite these risks, additional resources were not allocated in order to provide dedicated management cover for the service. Following our first day of our inspection we requested assurances about how the service would be managed. The provider informed us the regional manager would be supporting the service on a fulltime basis until a manager could be recruited.

● Quality audits were not completed at regular intervals. No overall audit of the service had been completed since our last inspection in January 2020. The regional manager told us they had completed themed audits as issues had arisen. They told us, "I've just been firefighting. I had concentrated on what was in front of me and try and prioritise." Despite these pressures and concerns the provider had failed to ensure the

organisation robustly assessed the quality of the service people received.
● Where individual audits were completed these were not always effective in making improvements within the service. An audit of the electronic care planning system was completed in May 2020. This had found significant gaps in information and guidance for staff which were still present during our inspection.
● The audit also reflected concerns regarding how people's daily care was recorded. The audit stated, "It was evidenced that upon reading these (daily records) at random the recording was poor. The document lacked detail and did not detail support or choices." Despite these concerns, we found no improvements to how people's care was recorded during our inspection.
● The approach to quality assurance was not co-ordinated. The regional manager told us support from different departments was planned to address concerns within the service. However, there was no overall action plan in place to monitor this, allocate responsibilities or provide timescales for actions. Following our request for assurances from the provider an action plan was forwarded to address concerns found during our first day of inspection.
● There was a lack of communication with other professionals. Health and social care professionals involved in people's care told us communication with the service was difficult. One professional told us, "They rarely answer the phone and when they do staff can rarely answer your question. They don't know who to put you through to so you just don't get a response. It's very frustrating and leads to delays. Everything is so slow."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● There was a lack of consistency within the leadership team. People and their relatives were not all aware of who the manager of the service was. One person told us, "It's been a bit difficult, I liked the last girl but I don't really know who is in charge anymore." One relative told us, "They're on their third manager now they don't seem to last very long." A second relative said, "I think the management has been all over the place, there have been recent changes. It isn't a major concern but it would be nice to have one person to go to."
● Staff did not always feel listened to, valued or supported. One staff member told us, "The management team are not approachable. It's difficult to put your ideas forward in case they take it the wrong way. They are not supportive and have the attitude we should just get on with it." A second staff member told us, "You need to have a leader and someone to guide you so it's been difficult."
● The day to day management of staff was not effective. Despite concerns regarding how people were being supported, no regular observations of staff practice were completed. Staff reported difficulties in supporting people when undertaking other tasks such as laundry and cleaning. However, senior staff had not worked alongside staff to review these concerns and directly observed the pressures staff faced. The regional manager told us they had recognised the need to increase the senior care staff team. They said they were therefore looking to recruit more staff with experience and qualifications to work alongside and mentor staff.
● Relatives were informed of incidents and safeguarding concerns. However, there was no evidence to show that when things went wrong, people or their representatives were provided with a written apology and explanation in line with the provider's policy. The regional manager forwarded an email requesting a relative was contacted in writing. However, the letter could not be found and no checks had been completed to ensure this had been sent.

The failure to assess, monitor and improve the quality and safety of the services was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Through the use of the auditing processes improvements had been made to how people's medicines were administered. The regional manager told us they had identified concerns regarding how medicines processes were followed. They had worked alongside the senior clinical lead to implement additional check and mentoring for staff. This had led to less errors and consistent recording.
● The provider had ensured notifications of significant events had been forwarded to CQC. Where additional information was requested this was provided in a timely manner.