Achieve Together Limited

Sheringham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sheringham House provides accommodation and personal care for up to 10 people aged between 18 and 65 years, who have a learning disability and autism. At the time of our inspection, there were 10 people living at the service. The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
The provider could not show how they met some of the principles of Right support, right care, right culture. This meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

Right Care:
The model of support did not always promote maximum choice and independence. The ethos, attitudes and behaviours of managers and staff did not always ensure that people led confident inclusive and empowered lives.

Right culture:
Although people told us they felt safe and were happy living at Sheringham House, the provider did not focus on people's quality of life, and care delivery was not person centred. Staff did not always recognise how to promote people's rights, choice or independence.

There were not sufficient staff to safely meet the needs of people. Supervisions with staff were not always taking place and were not effective in identifying shortfalls. Incidents of behaviours were not always recorded in sufficient detail to look for trends and themes.

People were not protected against risks associated with their care. The environment and equipment was not set up to meet the needs of people. The provider failed to ensure there was robust auditing to review the quality of care.

We did see instances where staff were caring and understood how to support people. People were

supported with nutrition and hydration.

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

Why we inspected
This is the first inspection for this newly registered service. We undertook this inspection to assess 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.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not 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

Sheringham House

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
Our inspection was completed by two inspectors.

Service and service type
Sheringham House 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. This meant the provider was legally responsible for how the service is run and for the quality and safety of the care provided. On the day of the inspection we were supported by the interim manager [manager], deputy manager and a senior service manager.

Notice of inspection
This inspection was unannounced

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 and communicated with four people who used the service. People who used the service who were unable to talk with us used different ways of communicating including writing and using their body language. We also observed staff providing support to people. We spoke with eight members of staff including the manager, deputy manager, a senior service manager and care staff.

We reviewed a range of records. This included five people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and supervision data and quality assurance records. A variety of records relating to the management of the service, including policies and procedures were reviewed. We also spoke with five relatives and one health care professional.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risks to people were not always appropriately assessed or measures taken to enable people to live safely in their home. For example, the manager told us there were people who had a compulsive eating disorder where they chewed on cigarette butts. The smoking area at the side of the house that was allocated for people and staff to use had used cigarette butts scattered on the floor which posed a risk to the person. One member of staff told us the person frequently ran to the smoking area and picked the cigarettes up.
- One person's assessment around reducing the risk of them picking up cigarettes from the ground was not appropriate and continued to place the person at risk of harm. It stated that staff were to, "Offer a small amount of the cigarette as an alternative to picking used cigarette butts from the floor." After the inspection the provider confirmed this guidance had been removed.
- Staff told us another person frequently ground their teeth and we observed this during the inspection. There was no risk assessment or reference to this in the person's care plan. There was no evidence of any guidance that had been sought from health care professionals to prevent dental damage as a result of the grinding. The manager confirmed this had not taken place.
- We noted the person had lost nearly two kilograms of weight between August and October 2021. The manager confirmed the person had not been weighed since. There was reference in the person's food and nutrition plan they were to be given food supplements. However as there was no record of the person being weighed since October 2021 staff could not be assured the person was receiving sufficient nutrition. There was also no formal monitoring of portions of meals the person was eating other than staff recording what type of food was eaten.
- The environment and equipment were not cleaned appropriately which put people at risk of infections. The flooring in the laundry room had a build-up of dirt and grime and the flooring in the dining room was dirty and there were remains of food debris. One relative fed back, "I was shocked at how grubby the house looked." One person's bed bumper was dirty and worn which would limit effective cleaning. The fabric on their wheelchair was also dirty.
- We noted the bin in the front garden that stored people's soiled continence aids was unlocked which was a particular risk for the people at the service that had Pica disorder (Pica is the eating or craving of things that are not food).
- The provider had not ensured monthly COVID-19 tests were being undertaken with people as per the government guidelines. The manager told us a blanket approach had been taken with this as there were people that had anxiety with the testing process. However, there were no risk assessments for each person relating to this.
- There was no formal monitoring of the staff lateral flow tests that the manager told us staff were required to do three times a week. . Staff were also required to have weekly PCR (polymerase chain reaction) tests however the manager confirmed one member of staff had not had a PCR since 13 December 2021 despite

having been on duty since then. This meant the provider could not be assured that staff were negative of COVID-19 when they came in to work.
● We asked the provider to urgently address the concerns relating to the smoking area, the lack of testing and recording of COVID-19 tests for staff and to weigh the person that was at risk of malnutrition. The manager sent us evidence this had now been addressed. We saw a photo of the smoking area that had been cleaned up, a photo of the COVID-19 test monitoring sheet for staff and they also confirmed the person had now been weighed and had put on two kilograms.

The failure to not always manage risks associated with people's care in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were elements to the management of risk that were safe. There were people at the service that had frequent seizures. Staff were able to describe what they needed to do and there was clear guidance in people's care plans. One member of staff told us, "With [person] he wears a helmet on his head so if he does fall, he's protecting his head. He also has epilepsy. He gets quite twitchy, so the staff are aware when he's going to have a seizure." Relatives told us they felt staff managed their family members seizures in a safe way.
● There were Personal Evacuation Plans (PEEPS) in place for people with details around how they needed to be supported in the event of an emergency. There was a 'Business continuity plan' that detailed what staff needed to do in the event of an emergency such as a flood or a fire.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● There were not sufficient staff deployed at the service which placed people at risk of harm. One relative told us, "They seem to be very low on the ground with staff." Another said, "They need a few more staff."
● We saw from their care plan one person was at risk when accessing the kitchen independently. During the inspection we observed the person climb through the kitchen hatch on two occasions from the dining room unnoticed by staff until they entered the kitchen. We saw from an incident report in October 2021 the person accessed the kitchen in the same way when the hob had been used and the surface was still hot.
● The manager told us there needed to be five care staff in the morning and six in the afternoon which could be alternated. They also told us that they were struggling to recruit staff and often there were only four staff on duty through the day and we confirmed this from the rotas.
● There were people that were funded for one to one support during the day and this was not being provided as there were not sufficient staff. For example, one person was required to have 10 hours a day one to one support to include taking the person out. However, this was not being provided due to the low staff levels.
● Staff told us there were not enough of them on duty each day and this was impacting on the safe care being provided. Comments included, "There is just not enough [staff], I feel like it's not safe", "Four [staff] is not enough. When I started, we used to have six" and "Someone may have an accident and we haven't observed it."

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were actively recruiting for more staff. They told us where possible they were using agency staff and tried to ensure it was the same staff to provide consistency of care.
●The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Using medicines safely; Learning lessons when things go wrong
● There were areas of the management of medicines that were not always safe. We identified the medicine administration record (MAR) had not been completed for one person from the previous evening. As the person had liquid medication the member of staff told us it was difficult to determine if it had been administered. The member of staff told us they would investigate this.
● Creams and eye drops did not have expiry dates or opened dates written on them. This meant there was a risk that people were having medicines that were not effective as the expiry date may have passed.
● Accidents and incidents of behaviour were not always reported or recorded which placed people at risk. Staff told us there were daily occurrences where the person became anxious and upset. The last recorded incident in the folder was in November 2021. The manager told us, "I would say I wouldn't be confident they are always completed as staff see things as their general behaviour." This information could be used to identify patterns of behaviour and subsequently develop effective management strategies to assist the person with their anxiety. One health care professional told us, "The behaviour charts are difficult to get from Sheringham House."
● The manager told us there had been an incident where one person had caused a significant injury to the manager in November 2021. We saw this had been recorded on an incident form however no additional training had been provided to staff on how best to avoid further occurrences. One member of staff told us, "We haven't had any support or training since the incident." The manager told us, "With [person], no training been given since the incident."
● We asked the manager if they had analysed all recorded accidents and incidents. They told us, "I haven't had a chance to do one yet and don't know when last one was done." This meant there was little opportunity to look for trends and themes to reduce further occurrences.

The failure to ensure accidents and incidents were monitored and that the management of medicines was always undertaken in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People's medicines were recorded in all the MARs and were easy to read. The MAR chart had a picture of the person and details of allergies, and other appropriate information. There were medicines prescribed on 'as required' (PRN) basis and these had protocols for their use.
● Staff undertook training around medicines and their competency was observed and assessed before they were signed off.

Systems and processes to safeguard people from the risk of abuse
● During the day we observed people were relaxed and comfortable in the presence of staff. One person told us, "[Person] is safe." Another told us, "It's nice and safe." A relative told us, "I have that confidence that nobody's being horrible to [family member]." Another said, "He's happy to go back when he's spent the day with us."
● Staff understood what constituted abuse and the procedures to take if they suspected any type of abuse. One told us, "It could be financial abuse, emotional, physical. If I was caring for someone and stealing their money or hitting a service user." Another said, "I would report it to whoever is in charge and fill in a report."

● The manager told us they remind staff of the safeguarding process, "We have the safeguarding policy put out for them to read. The senior has access to log them onto the system. We report them to safeguarding team, CQC and care managers."
● Staff told us they would not hesitate to raise concerns through the whistleblowing process. One told us, "I would report a million percent I would. I am here for the guys." The manager investigated instances of alleged safeguarding and informed the local authority where necessary.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The provider had not ensured the environment suited the needs of people with sensory needs. There was a purpose-built sensory room in the garden. However, this was not being used as it was storing furniture and equipment. A member of staff told us, "I think the sensory room could do with a big tidy." Another told us, "The sensory room is such a mess. In the winter months, it could be done up and people could have quiet time."

● Although people's bedrooms had been adapted to fit their sensory needs there were no sensory rooms in the main house for people to use. A member of staff said, "The house doesn't suit sensory needs." Another told us, "There isn't enough sensory inside the house." The manager told us, "More could be done with the sensory areas."

● The overall look of the home was tired and in need of decoration. We noted the walls needed painting and doors frames in some of the communal areas were chipped and scuffed. The walls in the communal rooms were plain and lacked a homely feel. A member of staff said, "I find the décor quite boring." Another told us, "Things could be done with the decorating. Could be brightened."

● There was furniture at the service that was poor quality. One person's mattress had just been replaced. The mattress was thin, and you could feel the springs on the side of the mattress. The dining room chairs were uncomfortable to sit on and did not provide adequate support. One member of staff told us, "The furniture is not nice to look at."

● People had lived at the service many years and whilst there had been an assessment of their needs and choices this was not reviewed regularly. The manager told us people were allocated a key worker. The key worker's role was to meet with people once a month to review their care to ensure it met with their needs and preferences. The manager said, "The key worker meetings are to document their [people] goals and their skills. Small goals to accomplish." The manager told us these meetings had not taken place for several months.

Failure to ensure care was designed to meet people's needs and preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw people's bedrooms were personalised around their interests. One person liked Disney and their room was filled with items relating to this interest. One person told us they liked their room. There were other people whose rooms were minimalistic, but this suited the needs of the people due to their autism. One relative told us, "He has always been like that. No decoration in his room and minimalistic as he likes it

like that."

Supporting people to live healthier lives, access healthcare services and support
● People did not always have adequate access to health care professionals. For example, the manager told us appointments for the dentist had been impacted during lockdown. However, there were people that had not seen a dentist since 2019. For one person this was crucial given their daily habit of grinding their teeth. When we asked the manager if appointments had been planned, they told us they had not, and only urgent appointments had taken place. They told us, "I don't know whether people's health care needs are being met."
● Another person had a diagnosed health condition that may impact on their long-term physical health. However, no steps had been taken by the provider to consult a health care professional in relation to this.
● We spoke to the manager about whether people's routine health care appointment were being planned. They told us, "We need to do reviews to the learning disability team. It's been overlooked I suppose. It's asked for and not followed up." They told us other referrals to the dentist and optician needed to be undertaken.

As risks associated with people's health needs were not always being met this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had ensured that urgent appointments had been made where necessary. One person when asked told us they would speak to a member of staff if they felt unwell. People had been referred to the Speech and Language therapist (SaLT) in relation to their risk of choking. We saw the SaLT had visited the person and guidance around their eating and drinking had been included in their care plan. Staff were also following this guidance. A relative told us, "When it comes to his health the home will always phone." Another said, "I'm quite communicative with them when there are issues on his health."

Staff support: induction, training, skills and experience
● Supervisions with staff to assess their performance and to provide support were not frequent. One member of staff told us, "I couldn't tell you when my last one was." Another told us, "We should have them so if I have any concerns, I can discuss anything."
● We saw from the supervision matrix that out of 22 staff 11 had not received a supervision for more than five months. Two of these had not had a supervision since March 2021 despite the service policy stating that regular supervisions should take place.
● Where supervisions were taking place, this was not always effective in identifying shortfalls in staff practice. We identified gaps around the recording of people's anxiety, the cleanliness of the environment and lack of meaningful interactions from staff with people. Areas for development that could have been addressed during supervisions.
● Staff were provided with training around the needs of people including autism awareness, epilepsy and positive behaviour support. However, the training was not always effective in ensuring staff were competent to provide appropriate care. One relative told us, "I think sometimes staff could do with understanding autism a bit more." They told us their relatives could display certain anxiety "It could be avoided if they understood why he does that."

As the provider had failed to ensure that staff received appropriate training and supervision this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed a full induction before they started caring for people. This included reading people's care plans and shadowing a more experienced member of staff. One member of staff told us, "The staff were

lovely. I couldn't fault the staff and I fitted right in."

Supporting people to eat and drink enough to maintain a balanced diet;
● The manager told us that menus for the week were prepared in advance where people would have the opportunity to choose their favourite meals to be included. The menus were shown to people in picture form to assist people with their choices. People were encouraged and supported to eat healthily, and we saw the menus contained a variety of nutritious meals for the week. People were offered drinks through the day and with their meals.
● Lunch on the day was varied for each person dependent on their needs and preferences. Staff told us that options were not offered to people at the time of the meal as this would be confusing for people with autism. The meals were staggered due to people that would take food off other people's plates.
● The meal was relaxed with people making their own decision about where they wanted to eat their lunch. One person chose to eat in their room whilst another was happiest having their meal whilst sitting on the floor watching their electronic tablet. Staff had also provided the person with a tea pot and milk so they could make their own cup of tea. Where needed people had plate guards which meant that they were able to eat independently.

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.

● During the inspection we saw staff asked people for consent before they delivered any care. One relative told us, "They wouldn't do anything without consulting me."
● People's rights were protected because staff acted in accordance with the Mental Capacity Act. We saw that there were decision specific capacity assessments in place in relation to finances, consent to care and medicines. There was also evidence of meetings where discussions took place with staff, family and health care professionals to ensure that whatever care was provided it was done in the person's best interest.
● We saw that applications had been submitted to the local authority where people's liberties may have been restricted for example with the locked front door and the locked kitchen.
● Staff understood the principles of MCA. One told us, "They have capacity to say yes or no to things. You have to assume they do have capacity."

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We found occasions where staff could be more attentive and considerate to people. For example, during the morning a member of staff sat with people in the lounge. There was little meaningful interaction by the member of staff with people other than acknowledge people when they stood up.
- On another occasion a member of staff was heard to say to a person repeatedly during lunch if they could stop grinding their teeth despite staff knowing the person could not control this. The manager said of this, "I wouldn't expect staff to tell him to stop grinding them."
- We did see occasions where staff were kind and caring towards people. A person told us, "I like everybody." On one occasion a member of staff gently rubbed a person's arm whilst speaking with them. Staff were seen to be friendly and encouraging towards people. Another member of staff offered to give a person a foot massage and chatted to them. The person was seen to be relaxed during this and fell asleep. A relative told us, "Staff are kind and caring. I get the impression they are quite fond of [family member]." Another said, "The staff are friendly, very much so."
- Staff fed back that people at the service meant a lot to them. One told us, "I love working here. You get a sense of purpose, seeing the guys smiling. Makes you feel good when you make someone feel good."

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

- Where people had no family involved in their care the provider had not always sought an advocate to support them with decision making. The manager told us, "There are a couple of people that haven't got family." There was no evidence in their care plans an independent advocate had been sought to support and represent the person.
- One relative fed back they were not confident their family member's views were listened to by staff. They told us, "He can express his views. I would question whether he is listened to."
- Care plans were mostly written in the first person and there were examples of where people had expressed their wishes. For example, one person liked to have a diary in place where visits with their family were planned. The person liked to mark off the days leading up to the visits. We saw this was in place.

Respecting and promoting people's privacy, dignity and independence

- People were not always supported with their independence. We saw in care plans there were people who should be encouraged to make their own meals with support from staff. However, staff told us they would often make people's meals for them and would lock the kitchen door to prevent independent access by people. We also observed this on the day of the inspection. The manager told us, "The kitchen door may be locked. Maybe it's to make their [staff] life easier sometimes."

● Staff respected people's privacy and before they entered people's rooms they would knock first. They also introduced us to people and asked them if they were happy to speak to us.
● One person had drink container items around the floor in their bedroom. Staff respected the person's wish for these items to be left where they were. A member of staff said, "They mean a lot to me, once the guys get to know you, you get used to their ways."

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People were not being supported to engage in meaningful activities. One relative told us, "They don't do enough with him." Another told us, "In recent months not enough activities."
● We noted from two people's daily diaries they had not taken part in activities that were important to them. Over 21 days in January 2022 no activities had been recorded for one person other than two visits from their relatives. Their weekly activity planner stated the person was supposed to have intensive sensory sessions, walks out, foot massages and assisting to prepare meals. On most days the diary stated they were walking around the house, sleepy or relaxing in the lounge. A member of staff said, "There isn't enough for them to do, impacts a lot. Some sleep more as not a lot to do."
● Although we saw one person went out on the day of the inspection this was not reflective of other people's experiences. For the two people's diaries we reviewed they had not been supported to go out during January 2022.
● Staff confirmed to us people were not being supported to go out. Comments included, "Staffing is low. The impact is they [people] don't get to out as much. It impacts badly as there's not much excitement" and "You can do activities (in the service), but they don't get a lot more than that. We need to get more staff to get out more." The manager told us, "Staff levels are impacting on how often people go out."
● During the inspection there was few meaningful activities taking place for people. We observed people walking around the house, sat in their room or sitting in the lounge. There were no planned activities taking place. The manager told us, "Its big on the agenda. Mainly getting the staff on the mindset of going out and doing things. Residents are bored."
● We saw from people's care plans they were asked about their 'Future/Aspirations.' There lacked sufficient progress with this. For example, one person stated their goals for skill building would be to enhance accessing the wider community. We found this was not happening. It stated in their care plan they would kick the door to indicate they wanted to go out. We saw the person kicking the door on the day of the inspection but was not supported to go out.
● Other people's aspirations included developing skills in the kitchen to include preparing drinks and snacks. Staff told us they had little to support people with this and we confirmed this with our observations. A member of staff told us, "We don't have time for residents to cook meals with us. I think it should be a cooking session for people." Another told us, "We don't have people come in and cook. Would be nice."
● Relatives told us they were not told what activities their loved ones had participated in each week. They said this was important for them to know. One told us, "They don't update me, I ask on occasion." Another told us, "They say to me that one of key workers will ring me but it's very hit and miss."

● Relatives told us their family members care plans had not been reviewed to ensure the most appropriate care was being provided. One told us, "There is an annual review which hasn't taken place for a couple of years." Another said, "A review of his care is long overdue." They said, "It's not knowing what is set out, no plan and everybody has become complaisant."
● Although staff were able to tell us what people's day to day needs were, they were not always knowledgeable on what people's passions were or their backgrounds. One member of staff told us, "It would help with his support if I knew."

Care and treatment was not always provided that met people's individual and most current needs. This is a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● Care plans had records in place, so staff knew how best to communicate with people. For example, one person's care plan stated they preferred to write down what they wanted instead of speaking. We saw the person was provided with a pen and paper to be able to do this.
● We saw care plans written in picture format and there were menus and posters around the service with photos and pictures for people to assist them to understand.

Improving care quality in response to complaints or concerns
● People we spoke with and relatives told us they would know how to raise a complaint. On person told us they would speak to the manager. A relative told us, "If I am unhappy about something I will go and see the manager."
● There was a complaints policy in place, and this was also in picture format for people. We saw complaints were recorded along with actions taken as a result. For example, a concern had been raised from a relative about one person's moving and handling equipment. The relative had a written response and it was agreed with staff what they needed to do moving forward.
● The manager told us of complaints being raised, "They [relatives] know they can call us, email over any concerns anything like that and we will address it straight away. Verbal complaints should also be recorded."

End of life care and support
● The majority of the people at the service were younger adults and conversations were not needed to take place around end of life care. However, the manager told us there were relatives that had put in place funeral plans.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had failed to identify the impact on the poor quality of life for people. It was clear from our observations of care and from records people were not taking part in meaningful activities and were not living their lives to the fullest. This had not been fully recognised by the provider. The manager told us, "[People's lives are] not as fulfilled as they could be, but this is what we want to get back to."
● The providers website stated there was a sensory garden, an activity cabin, and a vegetable patch, along with a trampoline and swings. However, the activity cabin was not able to be used and one relative fed back the trampoline was not able to be used as it was not suitable for adult use.
● There had been a lack of oversight from the provider to ensure staff were supported and felt empowered. Comments from staff included, "I don't feel valued, we come and do our jobs and that's it", "I don't feel appreciated, sometimes thank you would go a long way" and "Everyone is a bit deflated. Morale is quite low at the moment." However, staff did say they were thanked by the senior staff on duty. A member of staff also told us of the manager, "They're very good. They always say thank you and tell me when I'm doing a good job. They're quite supportive."
● The provided had recruited a new manager to the service who was aware of the work that needed to be undertaken. A new deputy had also just been recruited to support the manager. However, they often spent time in the office with the door shut which meant they were not as accessible to staff as they would have liked. Comments from staff included, "The office is always shut, we feel we have no back up", "Makes you feel uninvited" and "There is no management on the floor, it's a bit disheartening."

As the provider had failed to have robust oversight of the service this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives felt the leadership and communication at the service needed improvement. One relative told us they were not aware the registered manager had left. Comments included, "I didn't know the manager left. I have always found it difficult when members of staff leave, and you don't know", "The communication can be quite rubbish" and "Communication [is needed] with just general updates like a monthly update maybe because we live quite far away." One health care professional told us, "The previous manager, did not know

what was happening in the home."
● Systems in place to monitor the delivery of care were not robust and this impacted on the care that people received. Staff were required to do daily check lists of the cleaning at the service however this was not always being completed and we identified cleanliness concerns during the inspection. The service had first aid boxes however when we checked them there were multiple items missing from the boxes despite staff recording weekly that the contents were all there.
● We identified that stocks of no longer required or excess medicines were not being checked or recorded. A member of staff was unable to tell us the last time medicines had been returned to the pharmacy. Stocks were not rotated appropriately meaning medicines soon to expire were at the back of the cabinet.
● The manager told us staff had handovers at the beginning of each shift where staff were also allocated their roles for the day. A member of staff told us, "Not very good handover at times, you don't know what's going on. If any changes in meds you don't know." The manager told us, "They could be better. I think they could be better at passing over more information. Things like, prescriptions were ordered."

As the provider had failed to undertake robust quality checks this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives told us they were not always informed of changes at the service. One relative told us, "There was a period where it was unclear who the key worker was (to their family member) and that would have been helpful to know she was off." Relatives fed back there had not been relative meetings which they would have appreciated. One told us, "It would be good to have meetings." The manager told us, "Sometimes we get feedback from families about not going out. To be honest I haven't spoken to families recently."
● The manager told us a survey was sent to relatives in September 2021. We reviewed the completed surveys which in main were very positive about the care provided. However, one relative had fed back they would like to see a separate living room or quiet room for the family member. There was no evidence this had been taken on board or the relative contacted about this.
● Resident meetings were not always used as an opportunity to make improvements. We saw from a December 2021 meeting people had asked for more indoor and outside activities. We found this was not taking place.
● Staff attended a meeting in December 2021 where concerns were raised around the cleanliness and the lack of activities. We continued to find these concerns on the day of the inspection. The manager also told us, "It's difficult getting all staff at the meetings, some won't come on their day off and hopefully we can have one big meeting and to get their ideas."
● The manager told us they were in frequent contact with the learning disability team in support of people's care. They said, "As a team we could do quite a bit more. I think everything is impacting on the care."
● The manager told us their biggest challenge was, "Getting all the staff to work at the same level. The consensus is there is no involvement for people." They told us they were working with the deputy manager to improve on people's daily activities and to try an incentivise staff.

As the provider had failed to adequately evaluate and improve care this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were aware of the shortfalls at the service. They told us of their intention to improve audits and work with staff to improve their confidence. They told us there were also plans in place to decorate the home and to purchase more furniture for the home.

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

● Where incidents and accidents had occurred, we noted from the records that families were contacted. The manager told us they were aware families needed to be contacted and apologised to where there had been shortfalls in care.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.