Achieve Together Limited

Leopold Muller Home

Inspection report

Poolemead Centre
Watery Lane
Bath
Avon
BA2 1RN

Tel: 01225356482

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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

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.

About the service
Leopold Muller Home is a residential care home providing personal and nursing care for up to 22 people who are Deaf or deafblind. People often have a range of other complex needs including dementia, mental health, a learning disability and/or autism. At the time of the inspection up to 15 people were living at the home. One person was at the home on respite.

The home is over three floors and has lounges with kitchenettes on the first two floors. There was an activity space on the first floor and a dining room on the ground floor. Individual bedrooms were on each floor.

People's experience of using this service and what we found
People who were not autistic and/or had a learning disability were not kept safe or had their needs met at this home. Medicines were not always managed safely and risks were not always considered or mitigated. There were not enough staff supporting people with adequate communication skills.

People were able to access other professionals when their health declined. However, this was not always in a timely manner. Systems were not in place to help people make choices who lacked capacity. The provider and management systems were not identifying concerns found during the inspection. Neither were they ensuring people's care was in line with current legislation, guidance and laws.

Right Support:

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The model of care was not in line with current best practice. There was a focus from staff on encouraging people to eat at the same time in a dining room. Kitchen staff prepared the meals and there were limited opportunities for people to work towards independence, such as cooking for themselves.

People were not supported by enough staff who had adequate training to communicate effectively with them. The provider had not put systems in place to mitigate this risk and impact was identified to some people as a result. The environment was dated and in places damaged which the provider had plans to rectify.

Right Care:
People were not always treated with dignity and respect by staff. Occasions were witnessed throughout the inspection which illustrated this. Staff tried to interact with people in a caring way and there were key staff who promoted this. However, many times through the inspection undignified care was witnessed often due to a lack of understanding of people's needs. Examples seen was staff shouting down the corridor at each other about people's intimate care. Also, leaving doors open when delivering intimate care.

The activity coordinator did their best to involve people in games and group sessions. However, these were limited due to their availability and lacked support from staff with communication skills to assist. No people actively took part in their local community and no one was seen leaving the home during the inspection.

Right Culture:
People were not leading confident, inclusive and empowered lives at the home. Many people sat in rooms with little to no interaction between tasks that were required. Little respect was shown for people being part of the Deaf and deafblind communities. There was a lack of cultural opportunities for them.

The management at the home did their best to lead by example and we received positive feedback about them. However, they were unable to complete many of their management tasks due to supporting a large unstable staff team. The new provider had not updated their governance systems to take on a nursing home or services for people that were Deaf and deafblind.

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

Rating at last inspection
This service was registered with us on 30 June 2021 and this is the first inspection.
The last rating for the service under the previous provider was good, published on 5 December 2018.

Why we inspected
The inspection was prompted in part due to concerns received due to a change in provider and concerns around leadership, people's cultural needs being met and staffing. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

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.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to keeping people safe including from risks of harm and potential abuse. Breaches have been found related to staffing and staff training, people's dignity and culture, infection control, medicine management, personalised care and governance of the home at this inspection.

Following the inspection, the provider informed us they were going to slowly close the home making sure

people's needs and preferences were considered at all stages.

Follow up
We will meet with the provider and request an action plan of how they will keep people safe following this report being published to discuss how they will be proceeding with the closure of the home. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service until it is closed.

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 the provider has not closed the home, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement or closed the home 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**

Leopold Muller Home

Detailed findings

Background to this 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 Health and Social Care Act 2008.

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
This inspection was carried out by two inspectors and an internal specialist advisor for people who are Deaf who is a British Sign Language user on site. An Expert by Experience telephoned relatives; an Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The internal specialist advisor was consulted throughout the inspection when not on site.

Service and service type
Leopold Muller Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Leopold Muller Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.
Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the home changed provider and since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people using British Sign Language (BSL) or deafblind signing. We were unable to speak with other people who used the service because of their limited verbal communication. We completed a wide range of observations including using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two relatives on site and four relatives on the telephone about their experience of the care provided. We also spoke with 10 members of staff including the provider's representative, the registered manager, deputy manager, nurses and care staff. We reviewed a range of records. This included seven people's care records and a range of medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, action plans, quality assurance records, policies and other information the provider shared.

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 of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems were in place although not being followed by the management to protect people from potential abuse including the use of restrictive practices.
- One person was recorded as having a physical intervention used on them in an incident report in December 2021. The person's care plan had no guidance for staff on using physical intervention safely or consistently if they became upset or distressed. The registered manager and provider's representative were unaware this had happened, and the incident form had no 'manager's review'. They told us they would investigate this and update us. We raised it with the local authority safeguarding team. Following the inspection, the provider informed us that it was a staff clerical error completing the form after they had completed their investigation.
- Restrictive practices were being used in the form of bedroom door alarms around the home. This was to alert staff to certain people when they left their bedrooms. The nurses and registered manager had not identified this as a restrictive practice or ensured they were part of a person's Deprivation of Liberty Safeguard.
- Accidents and incidents which had been reviewed by the registered manager had not always identified potential safeguardings or learning to prevent it reoccurring. Records of unexplained marks were found including old unexplained wounds or on intimate areas of the body and no safeguarding had been raised. Following the inspection, we raised our concerns with the local authority safeguarding team.

Systems in place to safeguard people were not effectively being used so placed them at risk of potential abuse and restrictive practices. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People appeared comfortable in staff presence although became frustrated when staff did not appear to understand them trying to communicate. Relatives were positive about how safe their relatives were at the home. Most commented on how responsive staff had been.
- Staff had received either face to face or online training in safeguarding. However, five staff currently working shifts had overdue training. Staff had understanding of when they should raise concerns and who to.

Assessing risk, safety monitoring and management

- People were not being protected from significant risk of harm because staff were not recognising potential risks and care plans contained contradictions. Concerns were found in multiple areas of people's support including risks of pressure ulcers, choking and/or aspiration and entrapment from the use of bed rails.
- One person at risk of choking and/or aspiration was given the incorrect thickness of drink which multiple

staff were not aware of. Their care plan contained inconsistent information. No one other than a member of the inspection team recognised this person coughing multiple times following their lunch when the incorrect thickness of drink had been given. The registered manager agreed their speech and language therapist guidance had changed which was not clear in the care plan.

● Another person was coughing multiple times whilst eating an ice lolly. Again, no staff recognised this person coughing including permanent and agency staff. Their care plan stated they should always have one to one support. A member of staff was assigned to them. It also stated the person was independently able to eat with no real adaptations to their eating and drinking. The inspection team requested a review following the inspection where changes to their needs around eating and drinking were found by a specialist speech and language therapist. This included specialist equipment.

● People at risk of pressure ulcers had not always had clear systems in place to ensure they were repositioned regularly or in line with any instructions. Care records sometimes contained inconsistent information. The only recording of repositioning occurred in people's daily logs. They did not explicitly say how frequently or what position people were placed in to demonstrate it regularly was changed. This meant people were placed at higher risk of developing pressure ulcers. Following the inspection, the provider informed us some people were able to reposition themselves and there were no pressure ulcers at the time of the inspection.

● One person was found lying in bed on an air mattress designed to prevent pressure ulcers which had the warning light flashing. The registered manager and nurse were unable to say how long this had been flashing and whether it was working properly. They immediately replaced the mattress in case it was not. Following the inspection, the provider informed us this was the mattress adjusting the air in it.

● Risks associated with the use of bed rails had not been assessed providing assurance they were being used safely. Neither were the use of them in line with current Health and Safety Executive guidance. People were at risk of limbs being entrapped because some bed rails had no covers leaving exposed wooden bars with gaps. Other beds had additional mattresses creating a reduction in the gap to the top of the bedrail. This increased the chance of the person rolling over the top. The registered manager rectified this issue during the inspection after their awareness to the concerns had been raised by the inspection team.

● Risks to people in the event of a fire had not always been considered. No specialist alarms appeared to be in place to alert those who were deaf and/or deafblind. One of the inspection team, who was profoundly deaf, was not aware there was a fire test during the inspection until they were alerted by another member of the team. People's bedrooms did not appear to have visual alarms, if appropriate, despite the inspector being told they were by the registered manager. The fire risk assessment did not identify this shortfall. Neither had the provider's quality audit in November 2021. Following the inspection, we contacted the fire service.

Systems were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider informed us there were some delays to care plans being updated because of documents being provided following a specialists visit. Additionally, they were experiencing delays in receiving formal guidance from the specialists like a Speech and Language Therapist. They also updated us on actions taken following a fire risk assessment to ensure every person had an individualised evacuation plan. As well as this, they had purchased five emergency evacuation sledges to help people who were less mobile to quickly exit the building.

Staffing and recruitment

● People were not supported by enough staff to keep them safe, meet their needs, provide a good quality of

life and understand their communication. People were seen to get frustrated trying to communicate their needs and wishes to staff on duty. Other people sat with no interaction for long periods of time. Relatives reported that some key staff had been lost since the change in provider.

● Staff reported there was a reliance on key members of staff who had transferred from the old provider to new one. They often completed long hours with minimal time off. These staff communicated the home was like their second family.

● The home was staffed with a high level of agency staff which was partly due to the national staffing crisis. To keep consistency the management tried to keep the same agency staff. However, agency staff that were regularly working at the home had not been upskilled in British Sign Language (BSL) or deafblind communication. They were reliant on picking up key signs whilst on shift and the provider had not put any systems in place to mitigate risks to people's safety and ensure needs were met. One agency staff told us they had no induction. Another shrugged when asked about the quality of the induction. One of the agency staff was paying to privately learn some communication which could be used in the home.

● The provider and management had a system to determine the dependency level of each person. However, there was no clear system in place to demonstrate how allocation of staff related to this. Staffing calculation tools failed to consider the needs of people to live a safe and fulfilled quality of life. This meant people could not have their basic needs understood and met.

Systems were not in place to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were working at the home. This placed people at risk of harm and poor care. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, at the request of the inspection team, the provider took action to ensure at least one member of permanent staff who could use BSL was working both during the day and at night on every shift. The provider already had systems in place to try and recruit new staff. Following the inspection, the provider told us all agency staff receive an induction including agency nurses completing a one-week induction period.

● People were not supported by staff who had been through a safe recruitment process. The required pre-employment checks had not been completed in all cases. Examples include in relation to reference checks from previous employers, interview records not in place and incomplete inductions despite being signed off by the registered managers.

● The provider had already recognised there was an issue with recruitment records in November 2021. An action plan was in place to review all staff files, identify the missing documents and work with the human resources department to resolve these issues.

We recommend the provider considers current guidance on safe recruitment in health and social care and take action to update their practice accordingly.

Using medicines safely

● Medicines were not always managed safely. Some people who lacked capacity were having their medicines administered disguised in food or drink. There was no documentation in place to show how the decision had been reached, other than a brief letter from the GP. The provider's medication policy was not being followed because the policy stated that a clear record should be maintained. During the inspection the registered manager and nurses rectified this issue.

● Medicines were at risk of being damaged due to storage at a temperature over the safe maximum of 25 degrees. Records demonstrated that on some occasions the storage areas had gone above this. No actions to reduce the temperature had been recorded by staff despite having mobile air conditioning units in place. This meant people could have been administered damaged or effected medicine.

● Systems were not in place to ensure people received 'as required' medicine consistently and in line with their needs. The protocols did not always provide enough guidance for staff. Such as how to assess if someone required the medicine or what steps to take before administering it; especially, if it was to manage people's distress levels. Staff were not consistently recording information following the use of 'as required' medicine. This meant it would be difficult to assess how effective the use of the medicines had been and whether they were used appropriately by staff.

Systems were not effective to always safely manage people's medicine. This placed people at risk of harm or inconsistent medicine administration. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's preferences for how they liked to take their medicines and their method of communication were highlighted. Medicines requiring additional storage were stored safely.
● Staff were making sure STOMP guidelines were being followed. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project involving many different organisations which are helping to stop the overuse of these medicines. STOMP is about helping people to stay well and have a good quality of life.

Preventing and controlling infection
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. There were occasions through the inspection staff were seen leaving areas where intimate care had been delivered still wearing full PPE. One nurse did not wash their hands or change their gloves whilst supporting someone with a specialist meal through a tube into their stomach despite handling the telephone multiple times. This meant infections could spread internally into the person's body.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. New disposable aprons were hanging over handrails throughout the home. This meant there was a risk of cross-contamination. Some areas of the building were difficult to keep clean and free of cross contamination because of wear and tear. Paintwork and walls were chipped and deep scratches on surfaces. On the first day of inspection the laundry room had full washing baskets touching each other and on top of each other. The registered manager was not aware which items were clean or soiled leading to potential cross contamination.
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. Not all staff followed best practise infection prevention and control. For example, hair was not always tied back, and we saw some staff wearing nail varnish. On the first day of the inspection no staff washed or sanitised hands between or after supporting people with their food. They put on disposable gloves on at the beginning and did not change them until the end of lunch. This meant they were supporting multiple people with the same pair of gloves which could lead to cross-contamination. Some staff were correctly wearing PPE and the management reviewed lunchtime arrangements around PPE during the inspection.

Systems were not effective to ensure people were protected from infections spreading through cross contamination. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the registered manager took action to rectify some of the concerns we found. For example, reminding staff about best practice and organising the laundry room. We have also signposted the provider to resources to develop their approach.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● People were supported to stay in touch with those who were important to them. Some relatives told us about the interactive ways they had stayed in touch during the COVID-19 pandemic. Others were regularly visiting their family member at the home.

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.

Staff support: induction, training, skills and experience

- Permanent staff had been offered a range of training both face to face and e-training. This included safeguarding, positive behaviour support training and mental health training. There was also service specific training offered such as epilepsy awareness and supporting autistic people. However, there was mixed completion rates for staff of this training. For example, none of the staff had completed service specific training on supporting autistic people and diabetes awareness. This placed people at risk of harm and poor care by staff who did not recognise their health and care needs.
- New staff had not received a full induction. The provider had identified this concern in November 2021 but failed to take action to address the shortfall.
- Agency staff were not always having meaningful inductions which provided them with the skills to work at the home. There were records most had inductions prior to starting work at the service. One agency staff told us they had received no induction and started working at the home on the day of the inspection. Another agency staff member shrugged when asked about their induction which had been signed off.
- None of the agency staff regularly working at the service had specialist training to work in the service. This included no British Sign Language (BSL), deaf awareness and deafblind awareness. Impacts of this lack of understanding and communication were seen throughout the inspection. People were trying to communicate by signing to staff with no responses to their requests.

Systems were not in place to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were working at the home. This placed people at risk of harm and poor care. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Agency staff had their training checked prior to working at the service.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Most staff knew to gain people's consent prior to starting any task although communication barriers were there. For example, one person was supported to transfer from a seat to a wheelchair. The staff supporting made sure they were involved at every stage even if it was through facial expressions and the occassional BSL sign.
● People with limited communication, who use wheelchairs were at risk of their consent not being sought prior to being moved around or having their needs met. There were times when people were moved around the room without any consent checks from staff.
● People who lacked capacity or had fluctuating capacity had not always had their choices considered in line with current legislation. Examples of this were found in medicine management which had not followed the legislation or company policies. Also, restrictive practices in the form bed rails and monitoring devices. None of them had evidence that less restrictive options had been considered and they were in their best interest.
● Some capacity assessments found were not decision specific and lacked details. One person had a capacity assessment which read, '…The decisions made in [their] best interests is that [person] does not need to read, understand and sign the person-centred care plan. All medication is provided by trained staff. Bed rails are used to prevent [person] from falling out of bed. [person] is assisted to all areas of [the home].' Nothing had been documented to how the decisions were reached or whether any less restrictive options had been considered first.
● During the inspection, capacity assessments and best interest decisions were written for concerns found on the first day. We saw these on the second day of the inspection. However, staff had still not recognised the door alarms to alert staff were restrictions. This meant it was not clear if staff were able to recognise when capacity assessments and best interest decisions should be used without being prompted. This placed people at risk of not having their rights appropriately considered including exploring the least restrictive options first.

Care and treatment of service users was not always providing consent or following current legislation. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to monitor people's human rights and making sure they were not being deprived for most areas of their lives. The registered manager had an overview to make sure when DoLS were close to running out they could follow it up. They also chased up already applied for DoLS using this scheme.
● However, there was a note from a local authority stating they had forgotten to include restrictive practices in the DoLS applications they had made. This had not been rectified at the time of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were not supported by a provider or management who made sure care was delivered in line with standards, guidance and the law. For example, 10 out of 15 people living at the home during the inspection were autistic and/or had learning disabilities. The provider's own quality audit from November 2021 stated, 'Right support, right care, right culture' guidance was "not applicable" because "this is a nursing home."
● People whose needs had changed had not always been recognised due to the high level of agency staff who lacked knowledge and communication skills. When changes were noted the registered manager and nurses made sure changes were made to their care plans and relevant health and social care professionals

were contacted.

Supporting people to eat and drink enough to maintain a balanced diet

● People enjoyed the food they were offered. One person kept getting the inspection teams' attention every meal to sign how much they were enjoying the food. The kitchen always had vegetarian options on offer even though no vegetarians were living at the home. They had also been given people's dietary requirements and preferences. Choices could be made where people wanted to eat, and the food options were shown to people at the beginning of the meal.

● However, there were limited quality of life opportunities for people regarding the mealtime experience and developing their independence. There was a mealtime when the kitchen was serving food, and everyone was encouraged by staff to go to the dining room. People were not participating in preparing their own meals to increase their independence. Neither could they choose the time they ate their meals.

● Concerns were found for people who required specialist diets at risk of choking and aspiration risks. Eating and drinking records kept for people were vague with the content of what people ate and drank lacking detail.

● Records of people's weights were maintained, and staff identified where people were at risk of malnutrition. The staff did alert health professionals if a person's weight dropped so further support and care interventions could be sought.

● People who required food supplements via a tube into their stomach had clear guidance in place. Nurses had facilitated this in line with the guidance. Issues were witnessed during one person being supported with this by an agency nurse. We reported this to the registered manager who spoke with the agency nurse.

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

● People were able to access other health and social care professionals when their health declined. Although this was not always being recognised by staff due to communication issues and not knowing people well. This meant there could be delays to people being referred in a timely manner. One person raised they had tooth ache to the inspection team and the registered manager was unaware of this. It was then organised for the person to see a dentist. Following the inspection, the provider stated the person had opportunities daily to raise this issue with the nursing staff and they had chosen not to.

● The GP visited weekly so they could regularly see people. Outside of this the nurses had contact with them and a good relationship. When concerns were found during the inspection the registered manager was able to organise medicine for people.

● Care plans demonstrated people had seen a range of specialists including speech and language therapists, epilepsy and diabetes. However, there was a lack of connection with specialists in the Deaf community. Following the inspection, the provider informed us of a range of health professionals and providers with a deaf specialism the nurses and staff have previously worked with to update practices and learn from.

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

● People were able to personalise their own bedrooms. One autistic person had a sensory light curtain in theirs, others had pictures and objects that were personal to them.

● Improvements were required for the environment around the home. There was damage to paintwork and doors. Exposed wiring above doors where alarm systems had changed. The provider had recognised these needs in November 2021 and was working with the registered manager on a plan for improvement.

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 were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's privacy and dignity was not always being respected by staff. Most staff tried to show respect when taking people for intimate support. However, one person was taken for intimate care and multiple times the door was opened and staff came out leaving it open. Staff were calling down the corridor to each other about people they were supporting with intimate care. Other occasions were witnessed during the inspection of staff openly talking in communal areas about people's intimate care. We raised this with the registered who confirmed they would take action to address the concerns.
- People were placed at risk of undignified support with personal issues at times when no staff with British Sign Language (BSL) were on site. One person recalled events which happened at night and resulted in them having continence accidents on multiple occasions, without adequate support to maintain their dignity. Daily records confirmed an example of this had happened the previous night. The registered manager was not aware this had been occurring. Following an instruction from the inspection team, action was taken by the registered manager and provider to make sure at least one staff on shift could use BSL at all times.
- Little was in place to encourage a quality of life and independence for autistic people and/or people with learning disabilities. For example, staff were not supporting them to prepare their own drinks and meals or access the community.
- The staff, management and provider were not respecting and embracing the Deaf and deafblind culture and community. People did not always have the correct cane to distinguish between being deafblind or blind. Staff were unaware that red stripes should be on the white cane to determine this, so members of the public could be aware of a person's needs. No access to specialist BSL television channels and internet websites were accessible.
- People did not have access to other members of the Deaf and deafblind communities. No recent attempts had been made to enrich people's lives with other members of the community or attend events. Following the inspection and a representative of the provider shared some work they had completed in the past. No examples were seen during this inspection.

Care and treatment of service users were not always treated with dignity and respect that considered their protected characteristics. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had independence to move throughout the home if it had been risk assessed as safe. One deafblind person was seen independently moving multiple times from the upstairs living room to the

ground floor dining room without support. Others were seen able to go for cigarettes or choose how they spent their time.

● People were supported by staff who were doing their best to treat people kindly. Often this was limited by the lack of specialist training. Relatives expressed how caring the staff were. Comments included, "I think the staff are very caring," "The [staff] are delightful" and, "[Person] is well looked after."

● One member of staff had received recognition through the provider's employee of the month scheme after the care and support shown following the death of a person at the home. Comments about their award included, "[Staff member] and the team handled this devastating situation with such dignity and compassion."

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

● People struggled to express themselves in a way which could be understood by staff using their own languages. During the inspection we found impacts this had on people's quality of life and contribution to their care.

● Opportunities for people to share their views were made during more structured meetings where BSL interpreters were provided. For example, at care reviews and resident meetings. It was clear this provided valuable opportunities for people to express their views.

● Some relatives were involved in decisions about their family members care. One relative told us they were actively involved in the discussions around their mother's care. Another relative said, "I used to go down to reviews regularly."

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.

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

- People were not having care that was personalised to meet their needs and preferences to ensure a good quality of life. Some care plans lacked detailed guidance around people's specific needs. For example, one person who could become upset and distressed in situations had no detailed guidance for staff to follow. Examples of incidents were found demonstrating inconsistent support.
- Care plans had some details and guidance for staff to follow about people's needs and wishes. However, these were not always being followed during the inspection by staff. Examples were staff not knowing how best to communicate with people and what eating and drinking needs people had.
- People's quality of life was not being supported by personalised care that considered aspirations, life skills and vocational opportunities. People had not attended any form of education or employment. No autistic people and those with learning disabilities had ambitions or goals considered or facilitated at the home.
- People's care was not personalised through activities they were participating in throughout the day. Some people had specific support to access the community. Throughout the three days of inspection no people were seen accessing the community. People were seen for long periods of time doing nothing and eventually falling asleep. One person had a favourite activity taken away from them because an agency staff was trying to clean up. It was replaced with nothing.
- The provider was failing to ensure people had person centred care in relation to the Deaf culture and community. No opportunities to watch specialist British Sign Language (BSL) television programmes or online channels. People were not attending clubs or events related to the local Deaf communities. The décor had not considered supporting people who were blind to navigate their way around the home. Neither had it considered the sensory needs of autistic people. A member of the provider said this had happened in the past.
- Hobbies and interests were not always being considered as a foundation for activities for people. The registered manager was unable to name interests for one person who had lived at the home for around five years. They could only tell us they liked to go for a drive. At no point did this happen during the three days of inspection.
- An activity coordinator was doing their best to personalise activities for people. Throughout the inspection there was opportunities for people to participate in group activities and games. One person chose to play a board game with them. However, the activity coordinator was limited by staff who could communicate with people during the group activities. Additionally, most staff were not proactive in supporting the activities coordinator in occupying people.

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People were not having their specific communication needs met. Everyone at the service were either Deaf or deafblind. No regular agency staff had been provided guidance and support about BSL or deafblind signing. Multiple staff were seen not being able to communicate with people effectively.
● Alternative communication systems were not being used for people with learning disabilities and autistic people. For example, one person's care plan stated objects symbolising the choice should be used to help them make selections. This was not being used during the inspection. Neither were any other strategies such as pictures or symbols being used to communicate with people and help them navigate their day.

The provider had failed to ensure care and treatment of people was person-centred based on the needs and wishes of them. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us one person attended the educational day service during the inspection and another person went out for a drive. They also shared a range of celebrations and activities that had occurred earlier in the year or the previous year with a limited number of individuals.
● People were able to have their needs met through some visiting professionals. An aromatherapy specialist was seen spending time with individuals throughout the inspection visits. People requested their session and staff facilitated this happening. On the third day of the inspection a hairdresser was in and people were pleased they could have their hair cut.

Improving care quality in response to complaints or concerns
● Systems were in place for people to raise concerns. However, it became apparent that culturally some people were accepting of the care and support they were receiving whether it was of a good standard or not. The registered manager did take time to go around and spend time with people to capture their individual views.
● Relatives knew who they could go to if they were concerned. None of them had recently raised a concern. Comments included, "I would go to the assistant manager, but has not had to complain. Only had to clarify with the nurse or carer" and, "I can talk to the [registered manager] or [named staff]."

End of life care and support
● People had their end of life considered in line with their wishes or their family wishes if they were unable to make a choice. One relative was asked if they had inputted to their family member's wishes. They said, "A call happened a few years before COVID-19 and they were asked what they wanted to do should the event happen." Their views were respected and inputted into the plan.

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

- People were not being supported in a service that was well led to keep them safe, ensure their needs were being met and they had a good quality of life. Wide ranging concerns were identified throughout the inspection and many of them had not been recognised in either the management or provider level systems. This was highlighted by multiple breaches of the regulations found at this inspection.
- The registered manager was overseeing a large amount of agency staff covering the staff vacancies. They had prioritised hands on support for people over completing management work such as auditing systems and practices. Impacts of this were found throughout the inspection. For example, accident and incident reports had minimal or no manager response and new staff had incomplete inductions.
- Quality assurance systems at the home were not always identifying concerns found during the inspection which placed people at risk of harm and poor care. For example, fridge temperatures in kitchenettes had regularly been dropping below zero between June and August 2022. Neither had the temperature been taken daily as required. A 'food safety monthly audit' completed in August 2022 had not identified this. Neither had the health and safety audit identified the fire safety concerns found.
- The management were not making notifications to CQC or raising alerts with local authority in line with company policies and procedures and legislation. This meant external bodies were unable to monitor the quality and safety of care being delivered at the service. For example, when people had unexplained bruises or physical intervention was used a safeguarding to the local authority was not raised. CQC notifications were not always being made when a Deprivation of Liberty Safeguard was authorised.
- The provider and management were not ensuring current standards, guidance and the law were being adhered to. 'Right support, right care, right culture' was not being applied at the home. The British Sign Language Act 2022 was not being followed and neither was the Autistic Act 2009.
- The provider's policies and procedures were not being applied by staff and management of the service. For example, "Quality Assurance Charter" stated, "Person centred approaches and the ability to actively listen to and respond to the people that we support is at the heart of every aspect of support within Achieve Together." Multiple examples were seen throughout the inspection where this was not followed. Other policies not followed included recruitment, medicine management and the positive behaviour support.
- The provider's quality audit from November 2021 had not identified a wide range of issues found during the inspection. For example, around fire safety, choking risks, medicine management and statutory guidance they should be following. Although, it had identified 88 actions which required a response.
- The new provider had not updated their policies and procedures in line with acquiring specialist services

for people who were deaf or deafblind. For example, the 'Learning Directory' had no options for specialist courses on British Sign Language (BSL), deafblind signing or supporting people who were deafblind. This had already been raised by CQC to the provider in May 2022.
● Relatives had raised concerns about the transition between the two providers. Comments included, "Big difference from charity to multiple concerns…The change of ownership recently at the start of 2021 meant long term carers have left to go to another job" and, "Sadly the BSL interpreters left when the new company took over. Just feel that the last six months valuable staff that had been there many years have left. Shame they lost them."

Systems had not been established or were not working to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the provider worked with CQC and the local authority to try and mitigate immediate risks to people highlighted by the inspection team. They continued to work with both organisations following the inspection to improve the care and support people were receiving.
● Following the inspection, the provider informed us how seriously they were taking the concerns raised. They have reviewed practices and systems as a result of this inspection.
● People clearly knew and had good relationships with the registered manager. All staff we spoke with were positive about the registered manager and the support they provided including how hands on they were.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager told us they were open with people and relatives when things went wrong. We saw examples of this during the inspection. One relative said, "They would tell her if mum having bad or good days."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Meetings were in place to gain feedback from people including using BSL interpreters. During this they were reminded how to raise concerns and safeguarding issues. However, it was not clear action was taken as a result of comments made. One person wanted more staff to sign in the May 2022 resident meeting. No improvements were found at this inspection with staff communication.
● Relatives had a mixed opinion of the communication from the home. One relative felt there could be better communication whereas others felt they had plenty. Questionnaires and reviews had been sent out to them and health professionals. Comments came back included, "There are now many new faces [in the staff team]…not seen so much 'sign language' with the new staff" and, "[Staff] were very kind and nothing was too much trouble."
● Surveys from visiting professionals included comments like, "Welcoming professional service with excellent communication" and, "Fantastic at working with the medical team and ancillary services." When concerns had been raised such as the décor needing improvement and ways to retain staff no actions were listed as being taken.

Working in partnership with others
● Systems were in place to work in partnership with other health and social care professionals. A weekly doctor's round was in place to share any new concerns that were not urgent. When there were more urgent concerns this positive relationship led to quick responses.
● However, the management had not ensured there was contact with the local community and accessed it.

Neither were there management systems in place to ensure people's cultural needs were fulfilled.