Alderwood L.L.A. Limited

Alderwood L.L.A. Limited - Cransley

Inspection report

63 Loddington Road
Cransley
Kettering
Northamptonshire
NN14 1PY

Tel: 01604811838

Date of inspection visit:
16 October 2023
18 October 2023

Date of publication:
07 May 2024

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
Alderwood Cransley is a residential care home providing personal care to up to 6 people. The service provides support to autistic people with learning disabilities. At the time of our inspection there were 6 people using the service.

People's experience of the service and what we found:
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. Mental capacity assessments had not been carried out robustly by the provider to ensure people were supported to have maximum control of their lives and supported in their best interest safely, the policies and systems in the service did not support this practice. The provider did not have effective processes or systems in place to safeguard people to ensure they were safe from harm. Staff did not understand when a safeguarding needed to be reported to appropriate bodies. People were not supported by staff who had been appropriately trained and were competent. People had not received their medicines safely.

Right Care
People's care plans and risk assessments did not cover their range of care and support needs. Staff were not guided to support people in line with legislation, good practice and their training. People had not been protected from harm and abuse. The provider had not always provided staff with information and guidance to support people who were expressing distress and emotionally distressed to ensure people had positive outcomes. Individual risks were not always assessed or managed well, and this placed people at risk.

Right Culture
The service was not well-led. The governance system was not effective in monitoring the quality of the service provided to people. The provider failed to recognise risks and concerns in relation to health and safety, safeguarding, completing records and medicine management. The provider did not always ensure staff deployed had the right employment checks and skills to support people safely.

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

Rating at last inspection

The last rating for this service was Good, published 15 February 2022.

Why we inspected
The inspection was prompted in part due to concerns received about management, safeguarding and staffing. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, person centred care, good governance, staffing and dignity. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

Alderwood L.L.A. Limited - Cransley

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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 1 inspector, 1 senior specialist for people with a learning disability and autistic people, 1 medicines inspector and an Expert by Experience. Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Alderwood Cransley 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. Alderwood Cransley is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager was overseeing the service at the time of the inspection, who had submitted an application to become registered manager at the service.

Notice of inspection
The inspection was unannounced on 16th October 2023; we returned announced on the 19th October 2023 to Alderwood Cransley.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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
People living at Alderwood Cransley were not able to discuss the care and support they received with us. However, we observed care and support being provided to them. We spoke with 8 staff members, including the manager, regional manager, behaviour lead, team leaders and support workers. We also spoke with 8 relatives and 3 external professionals. We reviewed a range of records. This included care records of 6 people and their medicine records. We reviewed 3 staff files in relation to recruitment, 5 agency staff profiles and records related to the management of the home. During the inspection we continued to liaise with the provider to obtain additional documents which we reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to 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 and avoidable harm; Learning lessons when things go wrong

- People were not always safeguarded from abuse and avoidable harm. The provider did not learn lessons when things had gone wrong.
- Staff used blanket restrictive practices (restrictions applied across a group of people) without ensuring safeguards were in place to protect people's right. For example, staff used verbal, 'firm authoritative' commands and pictorial cues such as, 'put your hands down', instructing people what to do and not to do. These were not recognised by the staff as restrictive interventions and the provider did not have a monitoring system to evaluate whether they met ethical and legal standards.
- The provider failed to take robust action to protect a person and others from the risk of harm in response to identified increased risk in the local community. This led to a significant incident where a person and others experienced psychological and physical harm.
- A staff member described the same person showing signs of distress during a walk, however, they said it was in the person's best interest to continue. There was no consideration about the person's choice or that the activity was causing the person distress and increased risk of harm.
- The provider had failed to robustly review staff use of an unplanned physical intervention on a person. This was not in accordance with the provider' policy and procedure. This meant the provider could not be assured the right safeguarding actions had been taken to protect the person's rights and to reduce the risk of reoccurrence.
- Inspectors reviewed incident reports from the service. They identified there had been 46 incidents of a specific safeguarding nature (incident resulting in harm) and not all of these had been appropriately referred to the local authority safeguarding team or us being notified. This meant safeguarding incidents at the service were not subject to external scrutiny and people were at risk of not being safeguarded.
- There was a lack of robust incident analysis to address patterns of possible causes or staff members involved. For example, in one case the service identified an incident of harm was caused by staff not responding to the person's food choice. There was no further action recorded about how this should be addressed to reduce the risk of reoccurrence of psychological and risk of harm to the person and others.

People were not protected from abuse or improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- At the time of the inspection, the manager was in regular contact with the local authority safeguarding team to monitor and review ongoing safeguarding investigations that had been raised. The provider was aware safeguarding's had not always been managed appropriately at the service and they had recently

introduced new systems to ensure improvements were made.
● Staff had completed safeguarding training.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection
● Risks to people's safety were not consistently assessed, monitored, and managed.
● The provider did not consistently identify or mitigate risks to people, for example, recorded incidents for 12 months (October 2022-October 2023) showed a person experienced signs of swallowing difficulties. Risk meetings in July and September 2023 failed to identify this. Documented comments stated, "There are no concerns or issues with [person's name] and they continue to do well". A staff member told us the same person was at risk of choking and staff had to cut up their food. We asked the manager if anyone was at risk of choking on food or drink and they did not identify this person. They then identified 3 different people as being at risk and told us that risk assessments were not currently in place. This meant people were at significant risk of choking and increased risk of health conditions such as aspirational pneumonia. The manager told us they were taking immediate action to rectify this.
● Four out of six people at the service had known risks with constipation, however risk assessments had not been completed. This meant staff were not always aware of how to minimise known risks to people, or identify concerns, which placed people at risk of harm and increased the risk of health deterioration. The manager advised risk assessments would be completed for those at risk of constipation and that people at risk, had bowel monitoring charts in place to document bowel movements. Inspectors did not see these as part of the inspection.
● Risk assessments that were in place for people, had consistently identified the severity of risks to people as high. Where actions were recorded to reduce risk there was no further review to assess whether this was sufficient to reduce the risk to people's health, safety and welfare to an acceptable level. We raised this with the manager who told us they would take action to review.
● Chemicals hazardous to people's health were not stored securely in the kitchen. We raised this with the manager who told us this was against the service risk assessment and took immediate action to lock them away.
● We found one person had a key lock on their bedroom door. The manager told us there was no key available for the lock, however no one had considered the risk of the person being locked in their room. Inspectors identified the kitchen door also had a lock. This was a star lock, which meant there was no ability to use a thumb turn to unlock door from the inside. The manager told us they would take action to assess this.
● One person's visual cues that were kept on the floor in front of them were also placed on the dining room table in front of them, whilst they were eating. Staff we spoke with about this had not considered cross contamination. We raised this with the manager who said they would ensure the person and staff had multiple copies of the same visual cues to use so they could be cleaned in between use.
● People were not provided with hand wash or towels in their bathrooms. Staff told us there was a risk of people ingesting this, however, no alternatives had been considered to ensure people were supported with hand hygiene.
● People were supported to receive their medicines in a way that was not always safe. Inspectors identified a safeguarding incident had occurred from reviewing medication records at the service. We informed the manager we had raised a safeguarding concern to the local authority, in relation to the administration of 'as and when needed' medicines (PRN) given to 1 person on 2 occasions. Staff had given the person paracetamol PRN (used to treat pain) in-excess of the recommended safe frequency of every four hours.
● Managers and staff had failed to identify they had failed to follow safe medicine guidance or policy. This meant we were not assured about the safety of PRN medicines at the service. This left all service users at risk of not receiving medicines as prescribed.

● The service had organisational medicine policies in place; however local guidance information was found to be missing for staff. For example, information relating to how the provider was monitoring the storage of medicines in the cash box at the service, which pharmacy was making their supplies, and how the manager was ensuring consistency of MAR (medication administration records) at the service.
● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. The provider had failed to ensure hand washing products were available to both people living at the care home and staff and visitors when they need them.
● We found the environment was not always clean. For example, the kitchen floor was visibly dirty, with no sign of any recent cleaning. A pest control unit and extractor fan in the kitchen had not been cleaned for a period of time and the laundry room was not clean. This meant these areas at the service risked harbouring bacteria.

The provider had not consistently identified or mitigated risks to people in relation to their health , safety and welfare. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trying their best to mitigate risks for people with complex needs, however we found the documentation at the service for staff to follow was densely populated with repeated statements about people on multiple different documents. This meant there was a risk that the recommended control measures were not clear or apparent and putting people and staff at risk. The manager said they were in the process of reviewing current care documentation.
● The manager updated us following the inspection, to advise they had checked with a GP that the person had not come to harm following the medicine error's and they would be speaking to staff and completing additional training to ensure medicine errors were not repeated. They also confirmed that people's medication profiles had been reviewed and updated with the current medications.
● We spoke with the manager who confirmed they were aware of some of the infection control concerns at the service. They advised us that a new cleaning schedule had been put into place and environmental improvements were being made. They were awaiting the provider to update them further on plans.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● The provider did not always ensure there were sufficient numbers of suitable staff. The provider relied on a frequent high use of agency staff to cover people's care. This had the potential to put people at risk due to lack of knowledge of the service, people and systems. The manager stated they employed regular agency staff at the service to minimise these risks, however we were not assured as the agency profiles given to inspectors to review as part of the inspection did not contain all the mandatory training requirements or competency information.
● The provider did not always operate safe recruitment processes. For example, from 3 recruitment records reviewed by inspectors, staff had not completed application forms fully and incorrect dates had been recorded on records. They had subsequently been interviewed and the interview responses recorded by the recruitment panel were identical on multiple records and staff had not verified pre-employment references. Conduct information from previous employers had not been requested and gaps in work history had not been obtained. This meant the provider did not follow their own processes.
● Some staff were working extended periods of time without a break. Whilst staff had agreed to do this, we were not shown any risk assessments or evidence the management team had assessed how safe this was.

We could not be assured staff would be able to support people to the best of their ability working extended hours without a break.

● The manager told us that Disclosure and Barring Service (DBS) checks had been completed for all staff working in the service. (DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● There were enough staff to meet people's needs. Relatives told us they felt staffing levels were adequate and staff rota's confirmed this.

Visiting in Care Homes

● People were able to receive visitors without restrictions in line with best practice guidance.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to 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

- The provider had not ensured all staff had completed relevant, good quality training around understanding the needs of people with learning disabilities and autistic people.
- Not all staff demonstrated an appropriate level of knowledge about the wide range of strengths and needs people with a learning disability and autistic people may have, including their mental health needs, communication, positive behavioural support needs and any restrictive interventions. For example, we found staff did not always know the reason why they were providing support in a specific way. We were not assured staff understood the different strategies for providing support to people experiencing periods of distress. This placed people at risk of receiving inappropriate care and support.
- The provider had not checked staff's competency to ensure they understood and applied best practice in their support.
- The provider had not ensured agency staff were appropriately trained in supporting people with a learning disability and autistic people. Agency worker's training profiles did not always record whether they had any relevant previous experience or training and the provider's agency induction process was not robust. This meant there was a risk agency workers may not understand how to support people appropriately.
- The management team had not supported staff to keep up to date with legislation such as Right Support, Right Care, Right Culture. Staff were not confident in explaining how to support people in line with this guidance.
- The provider's Adult Development Programme (the providers model of support at the service), brochure on the provider's website referred to staff being trained in 'active support', however, we found this not to be the case. This meant information for the public and professionals was inaccurate and also meant staff did not receive training to support people effectively in engaging in daily life skills as advertised. We asked the Autism and Behaviour Support Lead about this training and they were unaware of this.
- Staff did not receive support in the form of continual supervision, appraisal and recognition of good practice. Supervisions had not taken place regularly.

The provider had failed to ensure staff were suitably qualified, competent, skilled and experienced. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager told us that improvement work has ongoing with regards to supervisions and appraisals for staff at the service including regular agency staff.
- Staff told us they had received induction when they started work at the service. Staff told us they had

received mandatory training for their roles.
● Staff had completed online training in areas such as the care certificate, safeguarding and supporting people to eat and drink. Along with face to face physical intervention training which was in line with the Restraint Reduction Network (RRN) quality standards.
● Relatives felt staff were trained, some more than others at the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People did not always receive care and support that was personalised or strengths-based that reflected their aspirations. For example, all people had the same tasks in their timetable such as 'yoga' and 'pen tasks'. We observed one person did not wish to engage in yoga. Staff respected this, however there was no further consideration about whether this type of exercise was of interest to the person or provided them with any benefit. We looked at the person's daily records which were not fully completed or stated 'No' to the person engaging with yoga. We asked the manager if there was an assessment of people's preferences and goals in relation to the provider's Adult Development Programme but they were not aware of this.
● People 'choosing not to engage' was consistently recorded by staff as a 'behaviour' rather than understood as the person expressing their rights and preferences. Records did not show any further consideration about understanding why people were not engaging with activities and tasks.
● The provider had not completed functional assessments to inform Positive Behaviour Plans (PBS) and 'Behaviour' meetings did not consistently seek to understand the root causes of people's distress and emotional reactions. This was against the providers' policy and procedure and national guidance.
● A staff member told us that people did not choose their own toiletries, instead the staff bulk purchased everyone the same toiletries. We saw a stock of toiletries were kept in the utility room. There was no evidence of how the service considered people's preferences and wishes.
● Most relatives felt the service assessed their family member's needs well.
● Some staff we spoke with had a good understanding of people's needs, while others could not explain why they were using certain choice tools with people.
● The manager told us they had plans to address this. Reviews of people's needs were being undertaken and care plans would be updated which would ensure people received care in line with their needs and preferences.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

● The provider was not always working in line with the Mental Capacity Act.
● The provider had not been monitoring people's DoLS authorisations and several had been allowed to expire. The manager could not locate the evidence confirming agreed restrictions had been considered under the MCA and they were agreed in people's best interests. Without seeing the documentation, we could not be reassured the principals of the MCA were being adopted and that all restrictions were lawful.
● There were no MCA assessments or best interest decisions in relation to positive behaviour support plans or for the use of people's photos to share with others. MCA assessments that were in place were out of date.

● We informed the manager and regional manager. The manager came back to us during the inspection to evidence what information they had gathered and how they had submitted new DOLs authorisations where needed.
● People's access to food was restricted and controlled by staff, snack boxes were kept locked in the manager's office. The manager told us these were people's favourite 'treats' used as motivators and rewards. There was no written guidance, mental capacity assessments or best interest decisions about this. The service had not considered the impact upon people's rights and choices, or the risk of it being used as a punitive method. A staff member told us staff were inconsistent in the use of the snack boxes which had contributed to a person's distress, emotional reactions and risk of harm to the person and others. The Autism and Behaviour Lead told us snack boxes were common practice across the provider's care homes, but they were unaware of them being locked away and said they would act to review this with the manager.

Adapting service, design, decoration to meet people's needs
● People's individual needs were not met by the adaption, design and decoration of the premises.
● The service did not look homely. There were numerous signs around the service detailing information for staff to be aware of in communal and living areas.
● Despite people living at the service for a number of years, the provider had not adapted the building accordingly. Inspectors found elements of the building still looking like how the building use to be used, as a hotel. This meant the provider had not considered this building to be peoples home.
● We could not be assured that people's sensory needs had been considered with regards to the communal areas and the interior/ exterior. The manager told us the environment was set out by the provider to be a low arousal environment to suit the needs of the people. However, there was no evidence to demonstrate how the provider or staff had considered the environment for the people living at the service.
● The garden did not look like it was regularly maintained and a relative commented, "The garden is looking a bit shabby."
● We discussed communal areas and the garden area with staff. They told us they had ideas.

We recommend the provider reviews the environment to see what improvements can be made for the benefit of the people who use the service.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink throughout the day.
● People were supported to eat and drink in line with their assessed needs. However, the staff team were fully in control of menu planning and what people ate. This limited the opportunity for people to maintain a balanced diet or eat what they chose all of the time.
● The manager told us they were reviewing the menus to ensure people were getting a balanced diet and food and drinks that they enjoyed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff requested support from health professionals such as GP's and nurses and advice from health professionals was recorded in people's support plans, however improvements were needed in this area following the concerns found in relation to how constipation and choking risks were being managed for people living at the service.
● Staff worked hard to put plans in place to help people get to health appointments and feel safe and at ease when doing so.
● Relatives told us, "[Staff] have taken [our relative] to the GP and they always tell us".

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with kindness and compassion. For example, some staff we observed and spoke with showed concern and empathy towards people. However, other staff appeared to be focused on getting people to complete tasks without meaningful engagement or relational support.
- One staff member described a person as stubborn and 'acting up' if they did not 'get their own way'. This was not respectful of the person's rights or empathetic to their needs and experiences.
- People's dignity and privacy was not consistently considered by the provider. For example, staff told us 1 person did not like window coverings and we found their windows were uncovered. Staff had not considered alternatives such as privacy window film or assessed the impact upon the person's sleep regime.

- The provider had not considered whether people would benefit from locks on their bedroom doors to promote privacy and protect their personal belongings. There were A4 signs on all bedroom doors with a photo of one person and a warning for them not to go in other people's bedrooms. Staff had not considered that this negative messaging could be punitive and demeaning for the person.
- Some language used in people's support plans was disrespectful. People were described as, 'non-compliant' and 'trying to cry'.

People were not consistently supported with dignity, respect and kindness. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We fed back our findings to the manager who said they were reviewing records and would speak with the staff team. However, we could not be assured they had a longer-term plan to address these issues and support staff to understand where they could improve.
- People were not always supported to follow their interests or take part in activities that were relevant to them.
- Relatives were generally positive about the staff team. Relative's comments included, "I'm impressed with their resilience " and "It's not always rosy but we're all honest. I can call and we discuss with each other. We work together".

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

- People were not always supported to express their views and make decisions about their care.
- The provider had not gathered feedback from people about their views of the care and support provided.

The manager arranged for staff to gather people's feedback during our inspection visit, however, we found the same questions and approach was used for each person, rather than being adapted to their needs. We observed staff supporting one person were not positioning the communication cards correctly. The manager confirmed the staff member had not received communication training in how to use the person's communication system.

● We looked at another person's communication system in detail and found this centred around limited activities and tasks offered by the service. There was no consideration about how the person could express what they were feeling. We found several written comments from staff about the person being tearful, however, there was no indication about how staff provided emotional support and reassurance. The person's positive behaviour support (PBS) plan advised staff to use a 'SHHH' picture in response to the person crying.

● Staff focused on telling people what not to do with constant visual cues 'DO NOT spit/kick etc, rather than guidance about what to do if they were feeling upset.

● Some staff knew people well and supported them to make choices such as what to wear or what to do in the house in line with their likes and dislikes. A relative told us, "[My relative] is always taken care of."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Outstanding. At this inspection the rating has changed to Inadequate. This meant people's needs were not met.

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

- People were not supported in a person-centred manner. The management and staff team had failed to understand or embrace many aspects of guidance such as Right Support, Right Care, Right Culture. This had led to a poor experience of care for people. However, people were not aware of this as they had been supported by the management and staff team in this way for a period of time.
- The provider's service model brochure, on the provider's website, stated it supported people with 'De-sensitisation', rather than assessing and meeting people's sensory needs as a valued part of the person's method for self-regulating. We found staff used approaches to stop a person's movement of tapping their face with their fingers. The manager told us this was to prevent the person causing injury to their face. However, there was no consideration of an alternative for the person to meet this sensory need. Instead, they were repeatedly told by staff to put their hands down on to a mat in front of them. Neither had this type of instruction or other 'assertive' commands been considered by the service as a potential restrictive practice. The service had not involved relevant professionals such as a psychologist or behavioural specialist to assess the suitability of this approach.
- Staff had not supported people to identify what they would like to achieve, nor had they supported people to achieve any goals they may have liked to pursue. When we raised this with the manager, they told us they had started to ask the people at the service and document this. They had also started to ask people's relatives for input. The provider had failed to treat people as individuals and work with them to live their lives the way they chose.
- People's support plans were not detailed in relation to people's preferences, likes and dislikes. There was little information to guide staff about what people's hobbies or favoured pastimes were or how they could engage people in these preferred interests. Many contained quite generic terms such as, 'likes music, puzzles, walks.'
- The management team historically had not meaningfully reviewed support plans and daily notes to help make sure people were at the centre of their care. This made it difficult to support people in a person-centred way or help identify where they needed more support to meet their needs.

Meeting people's communication needs

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.

● The provider was not always meeting the Accessible Information Standard. People's communication needs were not always understood and supported.
● The manager told inspectors staff used the Alderwood communication method at the service and this was based on the PECS (Picture Exchange Communication System). We were concerned as this communication function can be limited if staff only use this method to communicate with people. This is because the main goal of PECS or PECS-derived communication system is to teach requesting. This is only one aspect of communication and excludes expressive communication skills that are required for people to engage in social interaction. This meant, there was a risk that service users who have no spoken language could become very distressed if their needs were not met and they are unable to express their feelings.
● Although people had communication care plans at the service, these care plans did not include how they were encouraged or supported by staff to make requests or communicate their wishes. For example, one person's PBS plan stated that, 'Any issues, support was to be obtained from the internal Alderwood Positive behaviour support team'.
● Staff did seek support from an internal support team with regards to creating individual social stories for staff to use with people in order to help support them in a new situation, by breaking down complex social situations into simple, manageable steps.

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 always supported to maintain relationships, follow their interests or take part in activities that were relevant to them.
● People's care plans provided information about what they enjoyed doing; however, we found people's daily records did not always evidence these social activities were taking place. For example, in one persons' care plan it stated the person regularly attended church, however, in the daily records staff had just recorded 'no transport available'.
● During the inspection we were aware a number of people were experiencing a period of being unsettled and distressed. The manager told us they were not able to support people to go out if a person's distress impacted on their safety. However, we found this was not being recorded in people's daily records. This meant we could not be assured people were being offered the opportunity to go out regularly. It was not always clear how decisions about the safety of going out had been made, how the person had been involved and what alternatives had been offered.

People did not receive care and support that was personalised or strengths-based that reflected their aspirations. This is a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff knew some people's likes, dislikes and preferences. Staff had supported people for a long time and some people were engaging with staff.
● Some relatives were positive about the staff team. Relative's comments included, "I'm impressed with their resilience " and "It's not always rosy but we're all honest. I can call and we discuss with each other. We work together".

Improving care quality in response to complaints or concerns
● People's concerns and complaints were listened to, responded to and used to improve the quality of care.
● The provider had a complaints procedure in place. Relatives told us they would feel comfortable raising concerns and confident these would be dealt with.

End of life care and support

● The provider was not supporting anybody with end of life care at the time of the inspection.
● The manager told us people's end of life care wishes would be incorporated into their care plans when required.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were 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

- There was not a positive and open culture at the service. The provider did not have a system to provide person-centred care that achieved good outcomes for people.
- Staff felt they were supporting people in a way which empowered them and did not realise they were working in a closed culture which did not give people choices or support them to identify and achieve good outcomes.
- People were not being supported in a person-centred way. Staff did not understand the way they were supporting people such as denying choices, not supporting them to understand, leading to poor outcomes for people. The management team had failed to monitor how people were being supported to have good outcomes.
- The provider did not have systems in place to evaluate their internal 'Adult Development Programme' or their adapted 'behaviour' and communication approaches and tools. This meant the provider could not be assured these approaches were ethical or suitable to meet people's needs, in accordance with current best practice and national guidance.
- The provider could not demonstrate how their Adult Development Programme approaches consistently met the principles of person-centred care or empowerment. The service model brochure presented a menu of service-led approaches, which did not consider people's assessed needs or choice about whether they wanted to engage with the programme. For example, the brochure stated the approach would, 'reassure neighbours that all the people living in the home are helpful, law-abiding citizens, and support people to be good neighbours.' In practice, this meant one person's task was to litter pick in the local park. The service could not demonstrate how this met the person's needs and preferences or protected them from degrading activities.
- The provider's governance systems to review restrictive practices were not implemented in accordance with their policy and procedures or national guidance. For example, internal reports and audits on the use of restrictive interventions for the providers Clinical Governance Committee to review and monitor were not completed. This meant the provider could not be assured restrictive practices were used proportionately and lawfully to protect people's rights and prevent abuse, identify themes or learn lessons to feed into continual development and improvement.
- People's care records were not always up-to-date or complete. For example, people's timetables were not consistently completed, records in relation to people's epilepsy care were not up-to-date and contained inconsistent information.
- The manager was not able to demonstrate their knowledge of national guidance, dated January 2023,

regarding the Mental Health Act 1983 in relation to a person's care.
● Records showed post incident debriefs with people were inconsistent. This had not been identified by the service to learn lessons and make improvements.
● The provider was not able to demonstrate how they monitored the culture of the service or promoted positive values and behaviours in the staff team.
● Despite inspectors trying to engage with staff to seek feedback about the service and understand their experiences, very few staff were willing to engage, which indicated the culture at the service was not open.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The provider's system did not effectively monitor the quality of care provided to drive improvements. Audits had failed to pick up the issues we have identified during this inspection.
● The provider had failed to ensure regular reviews of medicines processes were undertaken with records of any actions required.
● The provider had failed to monitor people's DoLS authorisations, several had been allowed to expire. Notifications had also not been received from the service.
● Managers had not completed effective walk arounds in the environment. For example, spot checks had not included checking hand wash and hand towels for service users and staff at the service.
● The manager was unable to show how restrictive practices met people's assessed needs and no mental capacity assessments or best interest decisions had taken place. This was against the regulations, national guidance and best practice standards.
● The management team had failed to keep up to date with current guidance such as Right Support, Right Care, Right Culture. The management team told us they were not aware of this guidance and subsequently had not spoken about this with staff. As a result staff were not clear about how to apply this guidance within their job roles.
● The management team did not have plans to continually improve the service in line with nationally recognised best practice.

The provider failed to ensure systems to assess, monitor and improve the quality and safety of the service were in place and effective. This is a breach of regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection there was not a registered manager in post. A manager was overseeing the service at the time of the inspection, who had submitted an application to become registered manager at the service.
● After our inspection the manager provided a newly implemented report regarding the use of restrictive interventions at the service. However, this did not account for all restrictive practices used at the service and further improvements were needed to meet requirements.
● The management team told us they would take action to improve the service.
● Relatives were positive about the manager of the service. Comments included, "[They] have a real 'can do' attitude and [they] really have a handle on what needs to be done", and "Every time they have to change a worker or any change for example, they let us know straightaway. They're always updating us".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff were not always involved in the running of the service and their protected characteristics were not always well understood.
● Staff received a recent supervision and attended team meetings. However, when we checked the records,

we found they had only recently recommenced after a period of inactivity.
● Some staff reported frustration with changes in management and how the service was performing. All staff who spoke with us wanted it to be better for the people living at the service.
● Community engagement had decreased during the COVID-19 pandemic and this had not been fully recommenced. Relatives supported this view telling us a number of activities had stopped in recent years and they did not know when they would be restarted and/or replaced with something of equal importance.
● The manager was aware that a number of people had been affected during the pandemic at the service and had become withdrawn, however they were seeking support in how best to support them.

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 manager was aware of the duty of candour. During the inspection we were shown examples of letters written to people, and those important to them, to apologise when things went wrong.
● Relatives confirmed this. One relative told us, "[Staff] call us and ask. That's the thing, how they deal with issues, they fully inform us and they deal with it."

Working in partnership with others
● The provider worked in partnership with others.
● The management and staff team worked with professionals such as GP's and specialists to help promote good health outcomes for people. Raising issues and advocating for the people living at the service. For example, 1 person had recently been supported by staff to undergo a tooth extraction. Staff had taken time to support the person and ensure health professionals had all the information on how best to support the person, reducing the person's distress.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently supported with dignity, respect and kindness.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were suitably qualified, competent, skilled and experienced.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and support that was personalised or strengths-based that reflected their aspirations.

The enforcement action we took:

Served Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not consistently identified or mitigated risks to people.

The enforcement action we took:

Served Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment.

The enforcement action we took:

Served Warning Notice

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

The enforcement action we took:

Served Warning Notice