Wingreach Limited

Throwleigh Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Throwleigh Lodge is a care home providing support to up to 17 adults with learning disabilities, mental health support needs and complex healthcare needs which require support from trained nurses. At the time of our inspection 13 people were living at the service. The service provided bedrooms and communal areas over the ground floor and first floor of an adapted building.

People's experience of using this service and what we found
Despite provider assurances that the service had made improvements we found that this was not reflective of people's experiences. Concerns raised during the inspection have led to ongoing safeguarding investigations and urgent actions taken by the provider to keep people safe.

There was an absence of strong leadership to effectively coach and constructively challenge staff practices. This coupled with the heavy reliance on agency nurses and care staff meant that staff did not have the necessary skills and experience to deliver support in line with best practice.

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.

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

Right support:
• People were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible and in their best interests.
• Staff were not deployed in a way that enabled personalised and effective support.
• The continued breakdown in effective relationships and communication across all aspects of the service meant support did not always meet people's needs.
• Despite some well-meaning and caring members of staff, the running of the service did not support a culture of compassionate support.

Right care:
• People experienced delays in receiving care which subsequently left them at risk of harm.
• Support was task focused with an emphasis on managing people as a collective rather than enabling them to lead individual and meaningful lives.
• People had limited access to activities that developed their skills and independence.
• People were not always treated with privacy and dignity and this impacted on their basic human rights.

Right culture:
•The service lacked a positive culture and people were not at the heart of the service they received.
• There was a lack of accountability for mistakes that had been made, with a focus on blame rather than reflection and improvement.
• Provider oversight was reactive, and improvements were dependent on external pressure and support.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 23 February 2021). That was following a targeted inspection that focused on the Safe, Responsive and Well-led domains where we found multiple breaches of regulations. Following that inspection, we imposed a condition on the provider's registration which required them to complete an action plan and submit monthly evidence of the improvements that had been made. At this inspection, we identified that the service had not improved in the way we had been informed it had, and the provider was still in breach of regulations.
This service has been in Special Measures since February 2021.

Why we inspected
This was a planned inspection based on the previous rating.

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
We identified multiple breaches in relation to the safety of the care people receive, staff deployment, safeguarding, person-centred care and the management of the service at this inspection. We met with the provider immediately after the inspection and in response to our inspection feedback, they made the voluntary decision to close the service.

Since our inspection we have worked closely with the provider and local authority to ensure people received safe care as they were supported to move to new homes.

Follow up
At the time of publication of this report, Throwleigh Lodge has closed and therefore no longer providing a regulated activity. We have accepted the provider's application to de-register both the registered manager and location and these are now being processed.

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.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not caring.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Throwleigh Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Throwleigh Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
The first inspection day was unannounced. The provider was given 24 hours' notice of the second inspection day because we wanted to make sure managers were available to speak with us.

What we did before the inspection
We reviewed all information we had received about the service since the last inspection. This included the feedback received from our partner agencies, complaints and statutory notifications that had been submitted since the last inspection. Notifications are changes, events and incidents that the service must inform us about.

As a condition of the provider's registration that was imposed following our last inspection, we required them to submit a monthly update regarding the progress they had made towards improving the service in specified areas. We have also had regular online meetings with the new registered manager as part of our ongoing monitoring of the service. We used all the information shared within these updates and meetings to help us to plan this inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
Two inspectors visited the service unannounced on the first inspection day. We met with each of the 13 people who lived at the service and observed the support they received. We spoke with eight members of staff, including the registered manager and regional manager. We reviewed a range of records. These included the care plans for two people and documents relating to medicines. We looked at the recruitment information for three staff.

Following the first inspection visit, the lead inspector was given remote access to the service's online system and reviewed a range of care records for all the other people living at the service. A variety of records relating to the management of the service, including incidents and accidents and audits were also viewed remotely.

A third inspector made telephone calls to the family members of six people who lived at Throwleigh Lodge. We also spoke with three external professionals who had regular involvement with the service.

A range of serious concerns were identified by our remote reviewing of information and the negative feedback we received from some relatives. We sought some immediate assurances from the provider and the lead inspector returned to Throwleigh Lodge for a second visit. During the second inspection day, we went around the service with the Senior Clinical Lead and looked at the care needs, and risks associated with each person who lived at Throwleigh Lodge.

After the inspection
We collated all the information we had gathered and raised concerns with the Local Authority who arranged an urgent meeting with the provider and other professionals involved in the care of people living at Throwleigh Lodge. We also held an online meeting with the Nominated Individual and five other representatives from the provider's senior team to share our feedback and concerns. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The provider made the voluntary decision immediately following our feedback to close the service. We have therefore continued our monitoring of the service to ensure people were cared for safely until they moved to their new homes.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection in December 2020 we found that the provider had failed to ensure risks to people's safety and well-being were acted upon. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 12.

- The lack of oversight, monitoring and poor communication had resulted in people being harmed or placed at risk of harm. This was because appropriate action had not always been taken when risks were first identified.
- People had not always received appropriate medical care following falls and suspected head injuries. For example, the accident records for one person showed that they had fallen on 23/06/21 and was subsequently admitted to hospital in the early hours of the following morning. Daily notes indicated this person had showed signs of confusion and being unable to stand. However there was no recorded evidence of the action that had been taken to demonstrate the person was safe and not in need of urgent medical care.
- Medicine records for the person highlighted they were prescribed an anti-coagulant drug which placed them at risk of internal bleeding in the event of a head injury. The provider's policy in respect of managing suspected head injuries for people on this type of medicine had not been followed. Managers and staff were unable to confirm either verbally or in writing how they had monitored this person prior to the ambulance arriving 12 hours after the fall.
- Risks to health were not always managed safely. One person was prescribed an emergency medicine to be given in the event of a seizure. We saw an archived record which highlighted this person had previously experienced a cardiac arrest following the administration of this medicine. The current protocol in place for this medicine made no reference to this risk or how it could be mitigated.
- Risks linked to people's mobility were not consistently identified and managed safely. The accident records for one person highlighted that on three occasions since the last inspection they had slipped from their chair to the floor which had resulted in staff hoisting them back on to the bed. There was no care plan or risk assessment in place for this support. The person had not been assessed for the use of a hoist or measured for an appropriately sized sling.
- Where support plans were in place to mitigate known risks, these were not routinely followed. For example, one person was identified as being at high risk of oedema. The mobility plan for this person had been created following advice from the tissue viability nurse. This stated that the person should be supported to walk for ten minutes in every hour. There was no chart for monitoring this and this support was not provided during either of our inspection days. Staff on duty said they were not aware that the person needed to walk regularly and confirmed that the person usually only walked to either the dining room or

toilet.

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

● The risks in respect of fire safety that were identified at our last inspection had been addressed. Each person now had a Personal Emergency Evacuation Plan (PEEP) in place which outlined what support they would need to safely evacuate the building. Additional equipment had also been purchased to enable people to be safely transferred down the stairs in the event of a fire.

Systems and processes to safeguard people from the risk of abuse
At our last inspection in December 2020 we found that the provider had failed to ensure that safeguarding concerns were consistently reported. 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) Regulations 2014.
At this inspection we found that not enough improvement had been made and the provider was still in breach of Regulation 13.
● Managers and staff had not consistently ensured that correct procedures were followed in a timely way to ensure people were safeguarded from the risk of harm.
● The day before the inspection, the provider reported that during a visit to the service they had identified a person had sustained severe sunburn nine days earlier. This had not been treated or reported. Staff and managers were aware of the sunburn and yet had failed to take appropriate action. During the inspection, the person was admitted to hospital for treatment.
● Whilst there was some evidence of increased reporting of injuries and concerns and staff were aware of what constituted abuse, the process for raising alerts was inconsistent. We identified multiple care records which referred to people having sustained unexplained bruises, blisters and red marks on their skin where no action had been taken to either report or investigate the cause.
● Whilst relative feedback was mixed, one family member told us, "We have had three safeguarding issues with [person's name] now and I just want to move [them] nearer family now."
● Staff described how one person regularly became physically challenging towards them and other people. Care records referred to this person exhibiting "behaviour," but it was not possible to ascertain if staff had managed these situations safely. Staff were unclear about whether they used restraint. Where physical intervention reports had been completed, they provided no information other than the date on which the physical intervention had taken place.

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

Staffing and recruitment
At our last inspection in December 2020 we found that the provider had failed to ensure suitable and sufficient staff were deployed across the service. This was a breach of breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● There were insufficient suitably experienced staff deployed to meet peoples' needs in a safe and personalised way.

● On both inspection days we observed people waiting to receive care. These delays placed people at risk of both physical harm and emotional distress.
● On the ground floor, people were seen to spend their day sat in the same position, with staff rushing from person to person with enough time to only provide basic support.
● Feedback from relatives reflected our observations. For example, one family member told us, "If you walk through the home, they are just sitting in the living room or bedrooms staring at the walls."
● One-to-one funding was not used to appropriately manage people's complex needs. Risks had been identified in respect of the distress waiting for support caused one person. Despite having one-to-one support, we observed the person displaying physical behaviours when they had to wait an hour and a half for their request to go out to be met.
● The continued heavy reliance on agency staff meant that people did not always receive consistent support from people they knew and who understood their needs. One member of permanent staff told us, "Working with so many agency staff is very stressful, everything is on your shoulders. You literally have to do everything because people will refuse support if it's not someone they know."
● Similarly, another staff member told us, "There are two female residents on ground floor that require 2-1 for personal care, so the permanent female staff support them, and agency staff usually do the personal care for the men. That's an issue because, one of the males is very vulnerable and doesn't respond well to people he doesn't know." When asked what this meant for this person we were told, "If it's agency staff then he'll refuse to get up or stop eating and drinking."
● With only one permanent registered nurse who worked on nights, there was a lack of oversight of people's clinical needs. All day shifts were covered by agency nurses. There was a lack of accountability for following up people's medical needs which had resulted in delays to people getting the clinical support they needed in respect of their feeding tubes or catheter changes.

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

● New staff had been employed subject to the appropriate recruitment checks. Recruitment information included a full employment history, written references and the completion of a Disclosure and Barring Service (DBS) check for staff. DBS checks help employers make safer recruitment decisions and include a criminal record check.

Preventing and controlling infection
At our inspections in October 2018, January 2020 and December 2020 we found the provider had failed to ensure safe infection prevention and control systems were in place. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 for a fourth time.
● We were not assured that the provider was admitting people safely to the service. This was because we identified two separate occasions where people had returned from hospital and had not been supported to self-isolate for the required 14-day period.
● We were not assured that the provider was using PPE effectively and safely. This was because staff were not wearing full PPE when supporting the person who was required to be self-isolating.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We identified that some staff were not following good hand hygiene measures because they had either false or painted nails and were wearing multiple rings.

The failure to maintain adequate standards of infection prevention and control was a continued breach of

regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We signposted the provider to resources to develop their approach and immediate action was taken to remedy the concerns we raised.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
At our inspections in October 2018, January 2020 and December 2020, we found the provider had failed to implement robust procedures to monitor accidents and incidents. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was in breach of regulation 12 for the fourth time.
● There were factions within the management team and a division between permanent staff and agency staff. This meant when things went wrong the focus was on blame rather than reflection.
● Staff were unclear about where they were required to document accidents and incidents and as such there was a lack of management oversight over the events that had happened in the home.
● Where the cause of injuries to people had been identified, action had not always been taken to prevent re-occurrence. For example, the care records for one person made repeated reference to their shoes causing blisters to their feet. There was no record of what action had been taken to either address the wound or mitigate this harm. The person was still wearing these shoes during the inspection.

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

Using medicines safely
● People told us they received their medicines as prescribed and when they needed them.
● Relatives felt that medicines were managed safely. One relative told us, "They have got his meds sorted now and you can have a good conversation with him."
● Medicines were administered by the registered nurse on shift. We observed nurses on both days taking the time to explain to people what was happening and checked medicines had been taken prior to signing to confirm they had been administered. Where people required their medicines at specific times staff were aware of this.
● There were systems in place to ensure medicines were managed and stored safely and records were appropriately maintained.

Inadequate

Is the service effective?

Our findings

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

At the last comprehensive inspection in January 2020 this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Whilst applications for people who were deprived of their liberty had been made, there was limited evidence in respect of how other best interests decisions had been made. As such restrictions were in place, and it was not possible to evidence that other less restrictive options had been explored.
- Where people had bed rails in place, no assessments had been carried out to ensure these were the most appropriate option to keep them safe. The Regional Manager told us she was aware that these assessments were outstanding, but other areas had taken priority. The provider action plan had provided assurances this work would be completed by the end of May 2021.
- We observed that some staff supported people to make basic choices about their care, but staff were not aware of the status of their DoLS applications or what conditions were in place where they had been agreed.

The failure to provide support in line with principles of the Mental Capacity Act 2005 was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some generic restrictions that had previously been in place had now been removed. For example, one person told us, "I no longer have to have a plastic mug just because other [person's name] break them." The person went on to show how they now had their own china mug and teapot and said, "It was annoying because I don't need to use a plastic mug."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● Following the last inspection, the provider had made the decision to re-assess people's needs and support those people with higher clinical needs to move to alternative placements. This was part of their action plan to improve the quality of care at Throwleigh Lodge given the difficulties caused by being unable to recruit permanent nursing staff.
● Clinical assessments had been updated and support plans devised for people with higher needs pending these moves, yet this had not improved the way care was being delivered.
● A person had been assessed using a recognised tool as being at high risk of pressure wounds. Their clinical support plan for this included the use of a pressure-relieving mattress. We saw that the mattress had been set to the wrong weight for the person and therefore was not providing the required protection. Staff did not know what the correct setting should be, and managers agreed this placed the person at risk of pressure damage.
● Another person had been assessed as needing a new bed. A referral had been made to the occupational therapy team on 21/03/21 and was marked "Very urgent." There was no evidence of any follow-up action and the person remained on a double bed propped up on wooden blocks so staff could get the hoist underneath.
● Where clinical monitoring tools had been devised to monitor people's care following assessments that identified risk, these were not being used effectively. For example, where people had been assessed as needing regular position changes, the monitoring charts did not reflect the position we observed people to be in.
● At 10:30am on our second inspection day we observed a person sat in their wheelchair. Their position chart stated the person should be supported to change position every four hours. The last entry on the chart was at 5am that morning when the person was recorded as being in bed. It was therefore not possible to know how long the person had been sat in their wheelchair or when they required support to be moved again.
● The clinical assessment for another person identified they had a Stoma bag in situ which was required to be changed twice daily. From the person's daily records, it was not possible to ascertain if this support had been provided in line with the clinical assessment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had experienced delays in receiving appropriate healthcare treatment, because communication across the service and the monitoring of handover records was not always effective. For example, the person who had suffered sun burn had not received treatment in a timely way because despite repeated handovers about the condition, no one had taken responsibility for arranging a doctor to visit.
● Another person's records contained a body map had been completed on 24/06/21 that identified a blister and red marks to one of their feet. A nurse had indicated this was caused by the person's shoes. No follow-up action had been taken. We asked the Senior Clinical Lead to check this during the second inspection day, the person was still waring the same shoes and the blister was now an open wound.
● Initial progress in partnership working had recently deteriorated. A breakdown in effective communication with external professionals had further impacted on the way people received support. For example, miscommunication regarding the doctor's surgery had seen a withdrawal of primary medical services which had to be urgently reversed during the inspection.
● Another external professional told us that the factions between the management team, made it "Really difficult to communicate with the service and get a clear response."

The failure to provide care and support in line with a person's assessed needs and to support people to access appropriate health care and treatment to meet their needs was a continued breach of Regulation 9

(Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● With the exception of a few experienced and committed members of staff, there was a lack of specialism, knowledge and skill regarding the needs of the people accommodated at Throwleigh Lodge.
● One relative told us, "The home needs vigorous training" and another commented, "I think the staff have been trained the wrong way.
● Whilst there was evidence of a training programme in place, the lack of permanent staff meant that each day there were more agency than core staff working.
● One member of staff told us, "Even if we have the right number of staff, the skills is still the issue. We've had lots of training since the last inspection, including diabetes, break-away techniques, clinical skills, but the agency staff do not join in training, so there's just not enough staff on duty to do things the right way." Similarly, another staff member said, "We have the right number of staff on duty now, but quality is the issue."
● During both inspection days we observed that not all staff had the skills to support people effectively. For example, we observed staff struggling to support people to manage their behaviours, communication and clinical needs.
● New permanent staff spoke positively about their induction. For example, one new member of staff told us, "The induction was really very good. They put in extra days as this is quite a new role and they wanted to make sure we had covered everything." There was however a lack of training about people's specialist needs. For example, when we asked staff about people's clinical needs, they told us, "I didn't know that" or "I only read about that the other day and I don't think others know either."
● A lack of permanent nursing staff meant that people had to unnecessarily access external health care support which caused them delays and distress. For example, people who required support with catheters had to be externally referred because the nurses working at Throwleigh Lodge were not up to date with this area of training.

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

Supporting people to eat and drink enough to maintain a balanced diet
● People received adequate support to remain nourished and hydrated, although there was very little atmosphere and interaction at mealtimes.
● People told us that they liked their meals and it was evident from observations that people did have some choice around what they ate and drank.
● One person's medical needs had changed, and a very set routine of food and drink had become important to them. Staff supporting this person were aware of this and enabled them to eat and drink in line with their wishes.
● Another person had recently begun refusing to eat and drink and they had been appropriately referred to the dietician.
● Staff had easy access to list of people's dietary requirements, including recommendations from the Speech and Language Therapist. We saw staff referring to this information as they supported people with eating and drinking. One staff member told us, "Even though I know what thickness to make people's drinks, I still double-check every time."
● Where people required physical assistance to eat and drink, we saw that staff provided this support appropriately.

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

At our last comprehensive inspection in January 2020, we found the provider had failed to make appropriate adaptations to the design of the home. This was a breach of Regulation 15 (Premises and equipment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection, we found that whilst the environment was still not fully personalised and homely, significant refurbishment had been carried out to improve the safety and overall comfort of the environment and so the provider was no longer in breach of Regulation 15.

● The ground floor lounge had been entirely refurbished since our last inspection and now provided people with a welcoming and homely environment to relax. Furniture had been replaced and new sofas and chairs were now of an appropriate height for people to sit comfortably.

● Bathrooms had also been refurbished well and provided people with adapted shower facilities that were able to meet their physical needs.

● One relative told us, "They are making improvements. The home looks a lot tidier and more organised now."

● The registered manager was clear about the ongoing refurbishment plan for the rest of the home.

Inadequate

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 the last inspection comprehensive inspection in January 2020 this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity;
- Despite some well-meaning and caring individuals, the running of the service did not support a culture of compassionate support.
- The lack of permanent staff meant that people were frequently supported by staff who either did not know their needs and preferences or who were too busy to provide truly caring and personalised care.
- Some approaches were institutional by nature. Three males had recently been taken to the barbers for the same shaved haircut. When we queried how this, a staff member told us, "I think they [staff involved] did it to make life easier for them."
- Staff did not support people in a way that reflected them as equal partners in their care. For example, where staff were providing one-to-one support to people this was done in a way which was controlling rather than enabling. Staff were observed just following people around and watching them, as opposed to providing them with meaningful engagement.
- People spent long periods of the day isolated in their rooms, unable to change the television channel or put the radio on for themselves. When we visited one person in their room, they were sat facing a television which was on the menu channel of the DVD. The programme was not playing, and the introductory music was just repeating on loop.
- Some staff were visibly upset about the quality of care they had observed and asked for our help to make things better. One staff member said, "They don't care and only here for business and don't care about the clients." Another said, "I have to stay here and work because what will happen to my residents if I leave them?"

The failure to treat people with dignity and respect and support people in a way which protected their Human Rights was a breach of Regulation 10. (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence;
- Support was not always provided in a way that promoted people's privacy and dignity. Staff were observed to discuss people's personal needs openly in communal areas. For example, one staff member called down the corridor to another, "Can you take [Person's name] to the toilet, I think they need changing."
- We observed one person wearing a one-piece clothing item back to front. Staff said this was to prevent them stripping in communal areas, no consideration had been given to the dignity aspect of the person dressing in this way.

The failure to treat people with privacy, dignity and respect was a breach of Regulation 10. (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Support was predominantly task-based with set things happening at set times. At lunchtime there was no engagement with people eating in communal areas and we observed one staff member sat outside the dining area just watching what was happening.
- People's opportunities to express choice and control over their lives was limited if they lacked good verbal communication or strong external advocacy.
- One relative told us they had observed a staff member say to their loved one, "What do you want, tea or coffee? She said coffee, he said what about tea."
- People were not routinely encouraged to develop their independence or given opportunities to learn new skills. Whilst some staff were able to describe the individual things, they did to include people in their care, most of the care we observed was staff doing things for people in the quickest way.

The continued lack of personalised care was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Support was allocated and delivered in a way that focused on the task rather than the individual. People didn't always receive support that was personalised to their needs and preferences. We observed staff rushing from one person to the next without having the time to ensure people were left comfortable. For example, following personal care, one person was left in a poor postural position in their wheelchair with their hoist sling left crumpled under their legs.
- Another person displayed repeated signs of distress, and yet staff did not know how to respond. Their relative told us, "He has gone backwards …. he has deteriorated [since being at Throwleigh Lodge].
- We saw people spending large parts of the day asleep either alone in their rooms or without meaningful activity in one of the lounges. A relative confirmed they had witnessed the same on their visits, "They put her to bed early, keep her in bed until 4pm, her radio is never on."
- Despite the provider action plan indicating that care plans had been more personalised, this was not the case for everyone. The profile information for some people described only their diagnosis and physical needs, rather than what was important to them. With so many temporary staff working in the service, written information was key to knowing people's needs and wishes.
- Where care plans were in place, these were not consistently followed or reflected in the support we observed people receive.
- People's wishes or needs in respect of end of life care were not known or planned.

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

- There was a lack of opportunity for most people to engage in activities that were meaningful and fulfilling.
- Two people were able to articulate their interests and these were respected. The reality for other people was that most of their day, was spent doing very little in between receiving personal care.
- When asked how one person liked living at Throwleigh Lodge they replied, "It's okay apart from the boredom."
- One relative told us, "There is no stimulation for them at all." Likewise, another family member said, "I brought them a karaoke machine, but they never use it. The staff said they feel silly."
- On both inspection days we saw people spent hours alone. One person was observed sitting with the same box of sensory items on their lap for the entire day. Occasionally staff would pop into the room and spend a few minutes interacting with the person using one of the items from the box, but the rest of the time they were unable to gain any meaningful activity from this box at all.
- People were not consistently supported to go out when they wanted even where they had allocated one-

to-one staff to support them. For example, on the afternoon of the second inspection day a person was observed to be pointing to go outside, but staff refused to take them. We asked the staff member supporting them why this could not happen, and they told us, "It's a bit cold out there now." Instead the person spent their time sat on their bedroom floor either ripping newspaper or picking up plastic balls, with the allocated staff member just watching them.

The lack of personalised care and failure to support people to receive appropriate care that meets their needs and preferences was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff did not always have the appropriate skills to communicate with people effectively. For example, some people used Makaton as a way of communicating their needs, but not all staff were trained to use it. Makaton is a language programme that uses signs together with speech and symbols, to enable people to communicate.
● During the inspection we saw that one person was using Makaton to communicate that they wanted to go out. Their one-to-one staff member was unable to interpret what they wanted, and this become frustrating for the individual.
● Staff did not always respond to people's non-verbal expression of their needs. We observed that some people became frustrated or upset at times during the inspection, but this was either not noticed or ignored by staff.
● The provider action plan stated that they had introduced a range of communication aids to support staff engagement with people. These were unable to be located during the inspection and staff on duty were not aware they existed.

Improving care quality in response to complaints or concerns
● Complaints or concerns were not consistently listened to and used to improve the running of the service.
● Where people were unable to verbally articulate their concerns, there was no meaningful system for recognising their dissatisfaction. Whilst pictorial complaint procedures were available, there was no evidence to suggest staff had given people the opportunity to express their dissatisfaction.
● Relatives experience was variable, whilst some families said they either had no concerns or would be happy to raise them, others didn't feel their views mattered. One relative told us, "They [Managers] get personally upset about complaints instead of seeing them as an improvement point.
● One relative had had to complain repeatedly before there complaint was eventually listened to and resolved in an appropriate way.

The failure to act on feedback from people and other relevant persons was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection in December 2020 this key question was rated as Inadequate. At this inspection this key question has now remained the same. 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.

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

At this inspection we found that not enough improvement had been made and the provider was in breach of Regulation 17 for the fourth time.

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

- Despite significant input from CQC and other professionals, the provider had failed to deliver their action plan. The provider and registered manager had committed to improvements having been made that we found were not reflected in practice.
- Following the last inspection, we imposed a condition on the provider's registration that required them to submit monthly updates and audits to demonstrate the improvements being made. In addition, we met regularly via videoconference with the registered manager. Despite on-going assurances of compliance, we found the quality of the service that people received had not improved.
- Relatives, staff and managers were able to describe some of the changes that had been implemented, but ultimately these had not led to sustained improvements in the care that people received.
- Whilst regular audits were being carried, out, the impact of these on people's experiences had not been considered. For example, the electronic record system had been embedded and new handover systems had been introduced, but neither were being used in a way which ensured managers and clinical staff had a good overview of people's care needs and were responsive to their changing needs.
- Where accidents and incidents had been recorded, there was no meaningful follow-up or reflective practice to identify trends and mitigate future risks.
- People's physical and clinical needs had been re-assessed and yet, they were still not consistently being met which placed them at risk of harm.
- Staffing levels had been increased, but they were not deployed or managed in a way which ensured people were able to lead meaningful lives and receive personalised care.

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

- There was a negative culture across the service which focused on blame rather than improvement. There

was a lack of accountability for mistakes that had been made. Provider oversight was reactive, and improvements were dependent on external pressure and support.

● As concerns were identified throughout the inspection, managers sought to quickly blame others without reflecting on their own roles and responsibilities. For example, when we highlighted that the person who had returned from hospital had not been supported to self-isolate. The registered manager blamed the staff in charge and senior managers blamed the registered manager. Each layer of management expressed concern about those below them and yet had taken no action themselves to oversee or mitigate the risks they identified.

● Despite the recruitment of a new registered manager, existing divisions between staff and management teams still prevented progress being made. One staff member told us, "None of the staff get on, staff are leaving and there's no communication. The home is just a mess."

● The provider's improvement plan presented as a team of managers working together to deliver the work needed to bring the service forward. The reality was that individuals were working in isolation and against each other to the detriment of people's care. One staff member told us, "Senior managers are too focused on the records and not on the care."

● The service was not person-centred, and people were not empowered to lead active and meaningful lives. Support was consistently provided in a task-focused way which did not reflect people's individual needs and preferences. People's daily routines were designed to support the collective needs of the group and staff availability.

● Care was planned and recorded by managers with little involvement or input from people.

The failure to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People, relatives and staff were positive about the new registered manager but felt that they had not been successful in leading the service because there was a lack of clarity about manager roles.

● One relative told us, "I do think that the problem is at provider level. [The manager] has tried to make improvements but is micro-managed by [other managers]. I would like him to be in charge, but really he isn't."

● Likewise, a staff member said, "He is very open and really tries, but I feel perhaps he is restricted at higher level to implement the changes that need to be made."

● Some improvements had been made to the way relatives were communicated with. For example, one family member told us, "Communication from the new manager is better than ever before. They call every time he falls, which has never happened before."

● There was a lack of clarity about who was running the service. For example, one professional told us, "You get different information depending on who you speak to. The manager and deputy are not on the same page." This was also reflected in the disconnect between the provider and manager updates before the inspection and the delivery of care we observed.