Cambian Whinfell School Limited

Cambian Lufton Manor College

Inspection report

Lufton
Yeovil
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cambian Lufton Manor College is a college for students aged 16 to 25 with learning disabilities or autism and other complex needs. The college is spread across two sites, the main house site and Manor Farm. On each site there are several communal areas plus accommodation buildings. There are also five community houses for students to develop independent living skills. Not everyone who lived in the community received personal care. The Care Quality Commission (CQC) only inspects where students receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

At the time of inspection there were 88 students and 65 students were receiving a regulated activity. 11 students had a 52-week placement, 54 students were at the college for 38 weeks of the year. 23 students attended the college as day students; they did not receive either regulated activity. Students were placed by 22 different local authorities. Many of the students had limited verbal communication skills to express their experience.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that students who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for anyone with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. Students using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The college was a large service, with many smaller buildings used for accommodation. The main house site and Manor Farm registered for the support of up to 74 students. Over ten people were using the service. This is larger than current best practice guidance. However. the size of the service having a negative impact on people was mitigated by the layout of the college area and the fact some of the accommodation buildings had recently had the number of students reduced.

People's experience of using this service and what we found
Although students told us they were safe and happy we found the students were not being kept safe from potential harm and abuse. Students were at risk of being inappropriately supported when they were displaying behaviours which could challenge others. Not all systems were adequate to protect them from harm. Risks were not always being assessed. Those that had been identified did not always have ways to mitigate the risks. Some risks had been identified around the management of medicines. Students were placed at risk of potential harm because health and safety systems were not always effective.

Staff told us, and we found, they were working very long hours. There were discrepancies in how the management had identified the required staff levels. Some staff were working with students with specific health conditions. There was no training or guidance for staff to follow. Most staff were not receiving

adequate supervision.

The management were not aware of shortfalls found during the inspection and lack strategic oversight. They had incomplete systems in place to resolve issues when concerns had been found by them. Documents which should have been readily available during the inspection were not always easily produced. The management had plans for the future to try to resolve the issues.

Students were supported to have maximum choice and control of their lives. However, it was not always clear if staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Legislation did not appear to have been followed for some students who had significant restrictions in place.

Care plans for students were not always personalised. Sometimes they lacked key guidance for staff to ensure consistent care was provided and their needs were met. There were good links with other health and social care professionals including access to onsite therapists and professionals.

Students were supported by kind and caring staff who knew them well and often went above and beyond to prevent impact on them. Staff respected people's privacy and dignity throughout the inspection. Strong links had been developed with the community including for work placements.

The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

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 outstanding insert (published 8 April 2017).

Why we inspected
The inspection was prompted due to concerns received about medicines management, health and safety checks, staffing and the management of the college. A decision was made for us to complete an aligned inspection with Ofsted who had received some similar concerns and examine those risks.

We have found evidence that the provider needs to make improvements and students were at risk of harm. Please see safe, effective, responsive and well led domains sections of this full report.

The overall rating for the service has changed from outstanding to inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cambian Lufton Manor College on our website at www.cqc.org.uk.

Enforcement
We have identified seven breaches in relation to staffing, keeping students safe from potential risks of harm and abuse, personalised care, the management of medicines, use of restrictive practices, students lacking

ability to consent, notifying the Care Quality Commission in line with their statutory obligations and the systems in place to manage the college at this inspection.

We have also made a recommendation in relation to training for staff working with children and young people.

Following the inspection, we completed enforcement to the provider's registration so they had to send a monthly report on the actions they were taking to improve the service.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Cambian Lufton Manor College

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.

Inspection team
Three inspectors, one member of the medicine team and one assistant inspector completed the inspection. One of the inspectors was there for all three days. A second inspector, the member of the medicines team and the assistant inspector were there for the first two days. A third inspector was there for the last day of inspection.

Service and service type
Cambian Lufton Manor College is registered as a 'care home'. Students in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This part of the college was spread across multiple accommodation buildings across the main house site and Manor Farm.

Additionally, this college provides care and support to students living in five 'supported living' houses in the community, so that they can live as independently as possible. Student's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at students' personal care and support.

The college 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.

The registered manager was the head of care. They were supported by the principal of the college and the head of education, three deputy heads of care and home managers who were responsible for running each accommodation.

Notice of inspection

The inspection took place on 25, 26 and 27 June 2019 and was unannounced. It was aligned with an unannounced inspection from Ofsted. The college were jointly registered with CQC and Ofsted. Ofsted regulated the education being delivered.

What we did before the inspection
Prior to the inspection, planning meetings were held between Ofsted and CQC. Ofsted are another regulatory body who inspect locations delivering education to children and young people. We reviewed information we had received from local authorities including the local authority where the college is situated. We looked at any other information we held about the location. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 15 students who used the service. Some students had limited verbal communication, so we had informal interactions with them and carried out observations. We spoke with the registered manager, the principal, the head of education two provider representatives and 24 members of staff including, deputy heads of care, home managers, care, education and auxiliary staff.

We looked at eight students' care records and two Education Care and Health Plans (EHCP). We observed care and support in communal areas of accommodation. We looked at three staff files, staff rotas, quality assurance audits, staff training records, the complaints and compliments system, 10 medicine records, incident records, safeguarding records and environmental files. We visited three out of the five community accommodations.

During the inspection we asked for further information to some of our findings, including quality assurance documents. We received all this information in the time scales given and the information has been included in this report.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with four relatives and five health and social care professionals on the telephone. We also spoke with the fire service and local authority the college was placed in.

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 good. At this inspection this key question has now deteriorated 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

- Systems to protect students from potential abuse were not being managed in line with the provider's policy or current legislation. The provider's policy had three levels they used to categorise concerns, ranging from one being least to three being the most serious. Six level two concerns had not been raised with the local authority safeguarding team since February 2019. This included conduct of staff towards students and incidents between students. One of these concerns had little information about the actions management took to keep the students safe from a member of staff.
- Staff had not always followed the provider's policy around recording of potential safeguarding incidents within 24-hours. For example, one incident occurred on 31 March 2019 and the report was completed by a senior member of staff on 2 April 2019.
- External bodies such as the local safeguarding authority were not being informed in a timely manner about concerns, so they could monitor student's safety. Examples were found where five days had occurred prior to the safeguarding alert being made. On another occasion one local authority had to contact the management following an alert made by a relative.
- Inconsistencies existed between the systems used and information shared with other bodies such as the local authority safeguarding team and the Care Quality Commission (CQC). For example, one incident had been investigated by the local authority, yet no notification had been made to CQC.
- Students were not always being protected from potential harm when restraints were being used. Staff told us, and we saw debriefs were not always occurring following the use of physical interventions. Records were not consistent about how information was recorded. One student informed us they had been restrained lying on their back for a long time. The incident record stated staff had not received training in the restraint that was used. It was not clear what type of restraint this was and the member of management who had debriefed the staff member had not explored this concern. Following the inspection, we raised our concerns with the local authority safeguarding team. The provider updated us they had begun a full internal investigation into the restraint we had found.
- During the inspection, the registered manager informed us on work they had been completing to improve the recording of incidents and debriefs for students and staff. Some examples were shown of how debriefs to staff had improved. However, the positive impact of this new system was not clear from most of the incidents we saw because lots still lacked debriefs and details. Nor did staff tell us when asked if they felt there had been an improvement. One member of staff said, "It took five days for the principal to show their face about the [name of student] incident". Others agreed debriefs were still not regularly happening.

Systems were either not in place or robust enough to demonstrate protecting students from potential abuse. This placed students at risk of harm. 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.

● Students told us they were safe. One student said, "I am being kept safe". Whilst others told us how nice staff were to them. Relatives had more mixed views. They all spoke about the distance from the college so did not see the care and support as much.
● Staff understood how to raise a concern and most said they would be followed up by the management. All staff demonstrated an understanding of how to recognise potential signs of abuse. However, they did not have as much specialist training around children's safeguarding. The registered manager was a designated safeguarding lead for children's safeguarding although documentation was unavailable during the inspection in relation to their training. Following the inspection, the training information sent to us told us the registered manager needed to be booked on more advanced children's safeguarding training. The training records did not clearly show which care staff had received children's safeguarding training.

Assessing risk, safety monitoring and management
● Risks to students were not always assessed and ways to mitigate them found. Risk assessments missed some key information to keep students safe. For example, one student who had a specific condition that placed them at risk when being left alone in some circumstances. They had a support plan around bathing which did not mention the risk of being left alone whilst having a bath.
● Students with specific health conditions were not always kept safe and had risks mitigated around their condition. Two students with these specific conditions had staff supporting them who had not received training in relation to the conditions. One of the staff members had not received first aid training either. There was limited information in two students care plans about guidance for staff to identify how their conditions may manifest and what to do if they did. One student with this health condition lacked any risk assessment or guidance in relation to this. During the inspection the management arranged for urgent online relevant training for the staff members working with the students. They explained they wanted to keep consistency of staff for the students because this was important.
● In the community, students with the condition were also placed at risk. One care plan for a student who experienced symptoms relating to their condition failed to inform staff how to identify if the symptoms were imminent, signs to watch for and how to manage it when they occurred.
● Some students risk assessments were generic and lacked key information to provide guidance for staff. For example, one student at risk of choking had a risk assessment which did not contain enough information to keep the student safe or provide guidance for staff. Following the inspection, the provider showed us a detailed risk assessment which was now available for staff to follow. In the community houses, this was found as well. Risk assessments lacked details about student's specific health needs.
● Health and safety systems were not always ensuring adequate checks were being completed to keep people safe. No recent weekly fire alarm tests had been carried out for the Manor Farm and buildings on the main house site since February 2019. Following the inspection, we raised our concerns with the fire service about fire safety checks.
● Risks which could cause potential harm to students had not always been identified and ways to mitigate them found. Two unsecure grit bins were present on the main house site on the first day of inspection. There was a risk some students attending the college had a condition which meant they could eat non-edible items. By the second day these bins had been removed. Radiators were not always covered in student's bedrooms or in communal spaces on the main house site accommodation. Some of the students had complex needs and could lack understanding of the dangers when their levels of anxiety were high.
● The systems in place for staff to report maintenance issues to the maintenance team were not always effective. For example, in one of the accommodation buildings on the main site there was damage to the ceiling. The maintenance staff were unaware of this issue.

Systems were not always in place to ensure students received safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Students were not supported by enough staff to keep them safe both in the community, Manor Farm and the main house site. All staff, apart from senior management we spoke with told us they did not feel there was enough care staff to meet student's needs. Comments included, "We are all stretched. We cancel our own plans, so we can help the students. It is not fair on them if they have staff they do not know so we usually cover", "There is not enough of us", "I do not think it is recognised the amount of time we put in to make sure the students' lives are not disrupted" and, "We are knackered".

● Staff told us they were working additional hours to make sure the students did not miss out. One staff member informed they had completed a lot of hours recently. Records demonstrated some staff were working additional hours. This included one-night staff working over 392 additional hours in a three-month period. Another 16 staff had completed over 100 additional hours in three months. One education staff told us they had to go to the student's accommodation in the community to help get them up. They stated, "Some students do not make it to their sessions" because of being short staffed.

● Staff informed us some of the impact to students they had noticed was student's anxieties increasing. We witnessed one student stating they had a tummy ache so did not want to attend college. The staff supporting them told us this was a sign of their anxiety levels being high.

● There was a high staff turnover of staff. The provider's provider information return (PIR) in February 2019 told us 72 staff had left in the last 12 months. One relative told us the impact of staff turnover had on their family member which had led to more anxiety leading to incidents. The registered manager and principal explained there had been a change in culture since they started, and this was the main reason for staff leaving. The management told us about actions they were taking to recruit staff including open days.

● During the inspection two different staffing break downs were provided in relation to student's needs. One by the principal and one by the registered manager. These contradicted each other and did not always match all the staff levels we were told and found during the inspection. For example, one student was always receiving one to one support due to a recent increase in symptoms from their health condition. Neither breakdown listed this change. The registered manager informed us their version included the care breakdown and the principal's version was focussed on education. However, the principal's break down mentioned night staff levels required for each student.

There were not enough staff to keep student's safe and meet all their needs. This placed students at potential risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During and following the inspection, the management shared plans with us for reducing student numbers for the new college year in September 2019. They told us this would allow them to "stabilise" the college.

● Students were supported by staff who had been through a thorough recruitment process. This included checks from previous employers and criminal record checks. When staff had previously worked in care further checks were completed about their conduct. One member of staff told us, "One of my references did not come through and they asked for another before I started".

Using medicines safely

● Medicines were not always managed safely across the main house site and Manor Farm. Some students took medicines when required. Not every student would be able to express verbally when they required some of these medicines. There was not always guidance in place for staff to follow to make sure the

medicine was administered consistently.
● Students had medicines support plans and risk assessments. However, these did not always identify medicines risks and were not always signed off by staff. In one case the student's records contained reference to two different student's names.
● No student was having their medicines hidden in food without their knowledge. One student did have their medicines crushed and mixed with food. This was to make sure the person took their medicine. However, it had not been assessed to make sure the medicines were safe and effective administered this way. One of the medicines manufacturers leaflets stated it should not be chewed or crushed.

Systems were not always in place to ensure medicines were being managed in a way to keep people safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were ordered, stored and disposed of safely. Everyone had a list of over the counter medicines to treat minor conditions agreed with their GP. All medicine administered was recorded and each student's record was accurate. When students did have 'as required' medicine guidance it had usually been provided by external healthcare professionals.
● Students in the community houses had their medicine managed safely and staff had regular competency checks. Daily audits of stock and temperatures were checked of where stock was stored. One staff member said, "We are very anal when it comes to medicines lots of checks in place to make sure it is all correct and done properly". No students were self-administering their medicines. Although one student was being helped to transition to this.

Learning lessons when things go wrong
● Lessons had not always been learnt when things had gone wrong. Incidents had not always had clear debriefs for staff to demonstrate lessons had been learnt.
● Incidents which had involved medicines were recorded. However, learning or training needs to prevent further incidents was not always identified.
● The management had introduced systems to try and change the culture around accidents and incidents. A new system of monitoring accidents and incidents had been introduced. This allowed them to start to identify trends of students and staff involved. It also highlighted any themes to incidents. The registered manager told us they were completing training over the summer. Some training had already occurred.
● Meetings were now more frequently involving all the relevant staff from the school including clinical professionals. These could be called when there was an incident involving students to ensure ways to prevent reoccurrence. However, one recent significant incident was not on the tracker given to us as having a meeting.

Preventing and controlling infection
● The houses in the community were all clean. Students had rotas for housework and cleaning and were supported to keep their rooms clean. One student showed us the rota and explained they would be doing the washing up and taking out the rubbish on Thursday.
● Deep cleans had been arranged in the accommodation around the main house site and Manor Farm. These helped to keep a clean environment. Students were encouraged to actively take part in independent living skills which included keeping their accommodation clean. We saw one student was helping to clean their kitchen with a staff member.
● Staff had access to a range of protective clothing when supporting students with intimate care. They wore gloves and aprons to help prevent the spread of infection.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

For the main house site and Manor Farm site which were the registered care home, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes (which was the students living in the community homes), the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

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 in the main house site and Manor Farm site.

- Students had signed consent forms at the front of their care plans to consent to their information being shared. However, legislation had not been followed for those who had limited or fluctuating capacity to make specific decisions. Many students had fluctuating capacity living in all areas of the college. None of the care plans contained any information that this fluctuating capacity had been considered. One student had been identified by the college as requiring a DoLS due to lacking capacity about being supported closely. They had no capacity assessments or best interest decisions for anything else.
- In the main house accommodation and Manor Farm students lacked capacity for specific decisions. There had been no assessment of capacity and no best interest decisions for students. For example, students were being supported with taking their medicines fully and no capacity assessments or best interests existed for this decision.
- In the community, there were forms signed to show students had consented to their care plans and sharing of information. However, there was no assessment of capacity and no best interest decisions for people who might lack capacity. The registered manager informed us it was the responsibility of a member

of staff who had left to monitor these. Following the inspection, the registered provider informed us a replacement had been found for this member of staff who was due to start work shortly.

Current legislation had not been considered when students lacked capacity or had fluctuating capacity. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Legal processes were not being followed for students who had their rights restricted. Those who required constant monitoring and were unable to leave the college unaccompanied did not have DoLS in place.
● One health professional reported that the student required constant supervision. They had asked the provider to provide a checklist of how they supported the student to manage risk in the least restrictive way. No clear information had been given in relation to this.
● Following the inspection, one relative told us there had been a DoLS authorised for their family member. No records were seen of this during the inspection. Another student's relative was aware their family member was about to turn 18. They expressed concerned that no conversation about a DoLS application had been discussed with them yet.
● There was not an effective system in place to monitor the students who required DoLS. The registered manager told us they held a DoLS tracker and it was reviewed. However, we asked for all the authorised DoLS to check the provider was meeting the agreed conditions and mental capacity assessment being carried out. They were unable to provide us with this information. Following the inspection, the registered manager supplied us with a copy of the DoLS tracker.
● Students identified as requiring a DoLS on the tracker had no recorded action taken in relation to this. Two students had not been identified on the tracker despite being identified as requiring constant supervision. The registered manager told us a mental health practitioner was meant to be completing this work and had recently left. They were in the process of employing their replacement.

Systems were not robust enough to demonstrate the provider was protecting students from potential unlawful restrictions. 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

● Systems were in place to ensure students had access to advocates when required. Advocates can act as a representative of the student if they struggle to express themselves to others.
● The management were proud they were changing the culture around restrictive practices at the college. They were promoting staff to consider the least restrictive option even if this meant there was positive risk taking. For example, they had introduced games consoles and enabled students more freedom to walk around the college independently.
● Following the inspection, documents were shared with us which demonstrated the community houses had developed restrictive practices records. These identified what restrictions were in place and why. It also explored whether the student had capacity to understand the restrictions.

Staff support: induction, training, skills and experience
● Students were not always supported by staff who had received training to meet their needs. For example, some staff worked with students with specific health conditions without adequate training.
● Staff did not have adequate training in place to support student's who were still children and under the age of 18. One student had specific arrangements in place due to being under 18. Correspondence between a staff member and a social worker about a legally required review for this student were shown to us. One staff member confirmed they did not understand what the review was for or how to manage it.

We recommend the provider consider current guidance on training for staff who support children and young people and take action to update their practice accordingly.

● Most staff were positive about much of their training. One staff said, "We do a lot of training". Others told us about the specialist training they completed. This included supporting students with autism, specific conditions, managing behaviours which can challenge and first aid.
● New staff completed a thorough induction which took two weeks. This included training the management identified as essential to work with the students. Staff also completed shadow shifts during this working alongside more experienced staff. Staff had some mixed views about their induction. One new staff member said the induction had been "Intensive" and covered all the areas they needed to know. They already had care experience and said they found the modules they were working through good. Whilst another new member of staff told us their induction had been good but very disorganised. They said, "It was a bit frustrating as the session would be booked then the person doing it would not turn up for some reason." They added, "However, I love my work I would not change it for anything."
● The registered manager and principal told us they had a range of planned training sessions through the college summer holidays. These were to target areas they felt needed improvement. Staff confirmed these plans and were positive about them.

Supporting people to eat and drink enough to maintain a balanced diet
● During the day students could attend the canteen for lunch. On the menu was beef, ratatouille pasta, and a chocolate brownie for dessert. Healthy options were available which were soup and a jacket potato. The menu was displayed in a specialist easy read way on the board. There were enough staff in the dining area to support students. One student joked their mum's food was better.
● Students had enough food and drinks and were able to come and go as they chose. Staff were eating with students at their table, engaging in discussion and supporting them appropriately.
● Each of the accommodations had their own kitchens where students could store their own food safely and prepare meals. Students participated in planning their menus and participate in shopping for their food.
● In the community, students said they chose the food they ate; one house did a fortnightly meeting another weekly on a Sunday. Students would choose the food they wanted for the week and help with the house shopping. In the evenings, students regularly cooked for everyone in their house supported by staff. One student showed us the pizza they had made for the evening's meal. Care plans included allergies and food students liked and disliked.
● Students with specialist dietary requirements and eating needs had their needs met by the college.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Students had their needs assessed prior to moving into the college. Recent training had been conducted by the management to improve the quality of the information gathered. However, there were inconsistencies in the quality of assessments seen during the inspection.
● One of the inspection team requested an initial assessment for one student during the inspection. One senior member of staff was unable to locate it on their system. The member of the inspection team then asked the registered manager for the same initial assessment. The registered manager told them this would be given. It was not received.
● Another student's initial assessment contained some important details. However, other areas lacked information. For example, sections were blank around important personal details, identified risks and contact details of health professionals. The registered manager did not know the reason why information was missing. There was no further information or exploration in relation to these risks. Allergies, sensory and dietary needs for the student were not completed. The registered manager stated this could be because the student needed time to settle into the service.

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

● Students had access to a range of health professionals employed by the college. This included a psychologist, occupational therapists, dieticians and speech and language therapists. The therapists worked with the students both within the education day and care accommodations.

● Some care plans demonstrated how individual plans had been put in place by the therapists for staff to follow. There were sometimes concerns the care staff did not have adequate support to understand the plans.

● When staff were concerned about a student they could raise a referral form to the multi-disciplinary team (MDT). The clinical specialists attended these meetings and provided guidance about actions to take to support the student. For example, one student had displayed behaviours that challenged the service. Decisions were taken to put a reward system in place as a motivational tool. Additionally, it was recommended to put plans in to share the next days structure the night before. This was in place during the inspection.

● Links had been developed with external health and social care professionals local to the college. This included GPs, specialist nurses, podiatrists and the local learning disability service. Following the inspection, one GP informed us they worked with the college to immunise students on site to keep stress levels down. Other health and social care professional explained they were impressed at the reduction in anxiety and behaviour since student's they monitor had lived at the college.

● However, one health and social care professional raised concerns they had requested specific information and not received them. We informed the registered manager who assured us they would action this request.

● In the community, students had access to healthcare professionals when necessary. Care plans included evidence of reviews with GPs. Some students were in the process of transitioning to living in the community once leaving the college. One student had chosen to stay in the town they were already living in. Staff were working with them and the agency who were planning to support them in their new home.

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

● Student's bedrooms were decorated, when possible, to meet their individual needs and interests. Some had posters of their hobbies. One student struggled to have certain items in their bedroom due to anxiety. Alternative locations for things had been found. Some fencing round a garden area had been creating for some of the properties.

● When students had difficulty with verbal communication or literacy then alternative ways to prompt them were available. Visual labels using pictures and symbols were located on cupboard doors to act as prompts.

● Some of the accommodation had recently been updated and redecorated. This included reducing the number of bedrooms to increase communal areas for students. Other buildings still required this updating and there were plans in place to complete this.

● The community houses were adapted for the needs of people although a little tired in décor one will be closing as not considered suitable for young people.

● Throughout the college art work completed by the students was on display. These ranged in size and design to demonstrate some of the work completed by them whilst at the college.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant students had not always felt well-supported, cared for or treated with dignity and respect by all levels of the organisation.

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

- At senior management level it was not clear the students had been supported and respected equally and with dignity. Staff levels were not clearly demonstrating individual's needs and diversity had been considered. The safeguarding processes were not operated in a way that respected the diversity of all students in particular those under 18 years old.
- Students were supported by kind and caring staff. One person said, "Staff are OK" and continued to respond positively when asked if staff helped them. Another person said, "I like it here" and continued to say, "I love my staff". Observations demonstrated students appeared comfortable in staff presence in a variety of settings. All staff were respectful when they interacted with the students. One relative told us, "They [meaning the staff] have been incredible".
- In the community, all the students spoken with were happy with their home. One student said, "Yes" and put their thumbs up, "Happy". Another student was asked if they liked the staff and they said "Yes [name of staff member] is OK". Other students had caring and positive interactions with staff.
- Most of the staff told us how they had cancelled their own plans or completed additional shifts to ensure student's needs were met. They had gone above and beyond despite the difficulties to make sure the staff shortage had minimal impact. Staff told us, "I love working with the students" and, "I feel really passionate" when talking about helping the students.
- Compliments we were shown reflected the care and support given by staff. One read, "…a big thank you for all the care and support you gave [name of student] …". Another stated, "[Name of student] is very lucky to have you involved with his care".

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

- Students were supported to use a variety of methods to express their choices. This included using a special sign language which supported the speech of the staff member. It also meant the student with limited verbal communication could tell staff their choices.
- The national youth advocacy service visited the college once a month, so students could have their views heard. The advocate visited all the accommodation sites to speak with students and advocate on their behalf and follow up on any concerns and questions they may have. Records of minutes of meetings were seen. The registered manager and principal had recognised that a more specialist advocacy service was now required for the more complex students due to communication difficulties. They were in the process of resolving this.
- Staff were clear it was important to involve students in making decisions about their care. Staff were always asking students what they would like to do.

● Students were supported to maintain regular contact with their family and friends. One student spoke with their relatives daily in line with their wishes.

Respecting and promoting people's privacy, dignity and independence

● Student's privacy and dignity was respected. Staff knocked on doors before entering student's bedrooms. One staff member explained that although the student needed close supervision due to health issues they tried to give them personal space. They demonstrated how they did this to us whilst maintaining visual support at a distance.

● There was a priority given to promoting independence. One student said, "They have helped me to become a more independent young man". Students were able to travel round the college site independently. Some students had developed independent travel skills to access the community with the support of the staff.

● Ways to encourage students to be independent were explored. For example, a system had been devised to support a person to apply topical cream themselves.

Requires Improvement

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 outstanding. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- Students care plans did not always contain adequate information to provide clear guidance for staff in areas of risk. This led to a potential risk of inconsistent support and the preferred needs of students being met leading to raised anxiety in them. Although some staff had worked at the college for a long time, there was a high turnover of staff and use of agency staff who were less familiar with the students. One relative told us they had not seen their family member's care plan since the student had moved in to the college. Following the inspection, the provider told us they respected students wishes when it came to sharing their care plans with their relatives.
- Some care plans contained inconsistencies or had missing details. One student's care plan contained information in three separate places about two different types of hearing loss. The registered manager was not clear what type of hearing loss it should be and informed us they would get this changed.
- Key information was sometimes missing to ensure consistent support for students. One student had several identified areas which could cause their behaviour to change or place them at risk. However, there was no information for staff about how to support them in relation to these concerns.
- When students needed specific support with their intimate care there was not always enough detail to inform staff how to support this. For example, one student required help getting dried and dressed. No information to expand on how to do this was present.
- Students with health conditions did not always have enough details in their care plan to inform staff how to identify when their health deteriorated. For example, in relation to their epilepsy or choking.

Care plans did not always contain personalised details and on occasions lacked key information to support a student. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- All students had Education Health and Care Plans (EHCP's) and the two student records we looked at were up to date. An EHCP describes a child or young person's special educational, health and social care needs. They explained the help that will be given to meet those needs and how that help will support the child or young person to achieve what they want to in their life. However, the provider was unable demonstrate how they fully captured the outcomes about student's progression in line with their plans. The registered manager acknowledged this and explained they were plans to put systems in place to evidence student's support in line with their needs.
- One relative told us their relative had an EHCP for many years. They said the provider had supported them through a tribunal process. They added since their relative had used the service they had become more confident and looked healthier.

● Care plans in the community houses were person centred and included how each student's day could look for good or bad, what could affect their day and how to manage triggers for behaviours that might challenge. They were very clear about likes and dislikes and what could trigger behaviours. Staff were very clear about how important it was that written plans were not suddenly changed. All staff said they found the care plans informative. One new staff member was reading care plans as part of their induction. They said, "They are very clear I think I will know the person when I meet them."

Improving care quality in response to complaints or concerns

● Complaints were responded to in a mixed way and there was no clear system in place to monitor them. We looked at four concerns or complaints raised. Records were muddled yet we could see that the four had been investigated and actions put in place. However, there was nothing to show the actions had been reviewed by a manager.

● There was an undated feedback from one relative who had complained about the students EHCP was not being reviewed. They had been told in a response which not available to review that "Provisions were being implemented". The relative's response was that this was not accurate and had not happened. Another undated response from a relative said they did not feel their issues had been dealt with around some behaviour their family member had displayed.

● Meetings with relatives because of complaints had not always demonstrated a resolution. One complaint about the lack of transition support had been responded to with action plans followed up by a meeting with the relative. However, there was not a statement about the overall outcome. Another meeting with a parent said they thought communication had improved but other areas needed improvement and that they were unhappy that "The college had not lived up to their expectations." There was no recorded evidence in the records to show this had been followed up further.

Complaints systems were not demonstrating that management oversight was effective, and actions were being taken to learn from the concerns. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Students were able to tell us which members of staff they would speak with if they had concerns. Most staff knew people well so could identify when students were upset if they were unable to verbally communicate.

● Relatives had mixed opinions about how complaints were managed. One relative told us the college were quick to respond to some concerns they raised. However, another relative was concerned that despite multiple meetings following raising concerns actions had not been taken. Following the inspection, the provider sent us a positive example of how they had worked with one relatives concerns to create a positive outcome.

End of life care and support

● At the time of the inspection there were no students receiving end of life care and support. The management informed us they would consider this in the future if it was required.

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.

● Students were being shared information in a range of ways to meet their needs. Some students had staff using signs to support their speech to help them process the information. Others had visual prompts used in

the form of symbols or pictures. Special stories were used to help explain complex social situations simply.
● Speech and language therapists helped to ensure the right support was in place to communicate information to students. This included students having visual timetables to navigate through their day and guidance in care plans for staff to follow.

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.
● Students took part in a range of activities to meet their needs and interests. The college developed individual timetables which included work experience, horse riding, tutor sessions and independent living skills.
● Students we spoke with were positive about the range of activities they could participate in. One student listed all the activities they enjoyed. This included cooking, colouring and shopping. They were positive about the staff support during these.
● Compliments shown to us during the inspection reflected how relatives appreciated the support their family member received to participate in special events. One relative wrote, "We were absolutely thrilled that he coped so well – thank you".
● Students living in the community houses had access to a variety of activities. The students were involved in regular planned activities such as skittles and events organised by the college as well as activities they choose and organised themselves. Such as trips to the seaside, outings on a steam train and evenings at a local pub for a meal.

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

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Notifications of significant incidents were not always being sent to the Care Quality Commission (CQC) in line with their statutory obligations. Two incidents involving the police had not been notified to CQC. The registered manager accepted these notifications had not been made. One potential safeguarding incident was handed to the inspection team as already being notified to CQC. It was marked on the managements tracker as already notified. However, CQC did not receive this until five days after the inspection and 17 days after the actual incident. Several other potential safeguarding incidents had either been referred to the local authority and not CQC or neither.

The provider was not notifying the CQC in line with their statutory obligations. This was a breach of regulation 18 (Notification of other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

- The provider and manager failed to have effective governance and oversight that led to effective monitoring of care and improvements. This placed students at risk of potential harm and risk of their needs not being met consistently and safely. This also led to multiple breaches in the regulations been found. It also meant to students being placed at risk of potential harm, risks that their needs were not being met consistently and staff were working without the guidance they needed.
- There was a high turnover in staff and staff told us they were exhausted. Inconsistencies were shown to the inspection team about how staff levels were calculated by the management.
- Inconsistencies were found with safeguarding records, the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- On the second day, an incomplete improvement plan was shared with us by the registered manager. This lacked details about what actions needed to be taken, who was going to take them and by when. It also lacked information about shortfalls found during the inspection. For example, the inconsistent and sometimes missing information in care plans, the staff levels and some staff training.
- Issues were found with some documents which should have been readily available during the inspection having to be requested multiple times. For example, weekly fire alarm tests for each residential accommodation, the assessment of a student and copies of notifications sent to CQC. The registered manager and principal explained this may have been because two regulators were on site at once. Some of

the records required were not needed by both regulators.
● Information shared with CQC in the Provider Information Return (PIR) did not always match what was found on site. For example, risk assessments were not consistently in place for all risks to students. Safeguarding was not being managed in line with policies and in a timely manner.
● During the inspection it was clear the registered manager was not familiar with all the concerns raised to them. For example, they did not think any staff without training in a specific health condition were working with students with that condition. Nor did they appear to have knowledge of how many students were under 18 years old.
● The provider had recently employed a regional care lead to oversee and support the college and drive improvement around care. However, records of their visits demonstrated they had not identified concerns we found during the inspection.
● Most staff were not being effectively supervised at the college. Staff were meant to have supervisions every four to six weeks. Most staff told us they had not received supervision for a long time. Three staff records demonstrated this timescale had not been met. The registered manager stated this had been a challenge and there was no centralised recording system in place to monitor. In the community, another senior member of staff confirmed staffing levels had impacted on supervisions.

The lack of effective oversight, governance and quality monitoring arrangements was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and principal talked us through all their future plans to drive improvement at the service. This included some staff training over the summer months and consolidating the changes they were making by not having as many students in the next year. Following the inspection, further information was sent in relation to these plans including templates of new daily checks which were going to be used in the accommodation.

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
● Systems were in place to inform relatives and the person if things went wrong. When incidents had happened, records showed relatives were contacted. However, there were times not all relevant bodies were informed in a timely manner.
● Relatives had mixed opinions about the communication from the college. Some felt it was good, whilst others said they sent emails and there was no response.
● The registered manager and principal told us about plans they had to improve communication with relatives further. This involved employing an additional member of staff whose focus would be to regularly liaise with relatives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Surveys were regularly sent to the students and relatives. Students predominantly felt they were safe, and the care was good. However, the relatives survey was more mixed. One of the key concerns was the communication they received from the college. Some felt the college was excellent and supporting their family member well.
● Staff were positive about the on-call system developed by the management. They could use this during incidents when they required urgent support. There were three levels of on call in place, bronze, silver and gold. The registered manager explained this made sure the right level of support was provided.
● Students were regularly participating in meetings to express their opinions.
● Staff had mixed feelings about how much contact they had with senior management. Some staff felt the

registered manager was approachable and listened. Whilst other staff felt they did not appear as much as previous management. In the community, staff felt they never saw the registered manager and principal.

Working in partnership with others

- The college had developed strong links with the local community. This included with the local football club who supported students to meet their hobbies and wishes.
- A wide variety of local companies had good links with the college, so students could complete work experience. Some of these accepted students with no staff accompanying them.
- Health professionals both within the college and externally were regularly liaised with to meet the needs of the students. On one occasion there were delays to information being shared in a timely way.

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
Personal care	The provider had failed to ensure all care plans reflected student's current needs and wishes.

The enforcement action we took:

We asked the provider to send us a monthly report about improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Personal care	The provider had failed to act in accordance with the law and make decisions based on the principles of best interest.

The enforcement action we took:

We asked the provider to send us a monthly report about improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	The provider had failed to ensure care and treatment was provided in a safe way for students.

The enforcement action we took:

We asked the provider to send us a monthly report about improvements they were making.

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
Personal care	The provider had failed to ensure that students were protected from potential abuse and restrictive practices.

The enforcement action we took:

We asked the provider to send us a monthly report about improvements they were making.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure students received safe, effective and responsive high quality care and had not fully put in place systems to monitor the quality of care students received. Those which were in place had not operated effectively to ensure compliance.

The enforcement action we took:

We asked the provider to send us a monthly report about improvements they were making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet student's care and treatment needs.

The enforcement action we took:

We asked the provider to send us a monthly report about improvements they were making.