The Turning Point Project Ltd

Jaden House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Jaden House is a residential care home providing accommodation and personal care to up to 5 people. The service provides accommodation and support to people transitioning into more independent living. At the time of our inspection there were 5 people using the service.

People's experience of the service and what we found:

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

Right Support: People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were required to have their medication administered to them in the office by staff and not in a location of their choosing. This included people who had been assessed as being able to store and administer their medicines independently. People were restricted access to communal areas of the home as there was a process in place where people were not to be in communal areas of the home after 11pm. People did not have their own front door key and were not able to access their home independently.

Right care: Care was not always person centred. We observed some systems in place did not provide people with the opportunity to retain and develop their skills. We saw people's care plans lacked detail, The registered manager told us "Some staff support people more then other staff", This meant people sometimes had inconsistent support. Risk assessments were not always in place or did not provide enough detail. People were at risk of harm because staff did not always have the information they needed to support people safely.

Right culture: The ethos, Values, attitudes and behaviour of leaders and care staff did not always ensure people using services lead, confident, inclusive, and empowered lives. We saw records of staff interactions with people that was controlling. People were not always involved in the development of their care plans. People were not always involved in decisions being made about their daily routine or the tasks that they were expected to complete. People were not always listened to when they made suggestions on how they wished to be supported. There was an increased risk that people felt disempowered, isolated and less likely to engage with the staff.

Medicines and recruitment were not always managed safely.

Accidents and incidents were not always managed safely or reported appropriately.

The providers quality and risk monitoring systems were not always effective in identifying and action on shortfalls to ensure that people received safe and high quality care.

Infection control and fire were managed safely.

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

Rating at last inspection
The last rating for this service was Good (published 18 November 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service and the length of time since the previous inspection.

We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. please see safe and well-led sections of this full report.

You can see what actions we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Jaden house on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, Person centred care, safeguarding people from abuse ,and governance at this inspection.

Please see the action we have told to take at the end of this report. We have served warning notices for the breaches of regulations 13 and 17.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.
Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well-led.
Details are in are well-led findings below

Jaden House

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of 2 inspectors.
Service and service type
Jaden House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Jaden house is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed other information we held about the service, such as notifications. These are events the provider is required by law to tell us about.

During the inspection

We spoke to 4 people about their experiences of the care and support they received. We spoke to 5 members of staff including the registered manager and 4 support staff. We reviewed a range or records which included support planning documentation, and medicines records for 2 people. We looked at 5 staff files in relation to recruitment and a sample in relation to supervision records. We also reviewed a variety of records relating to the management of the service, including risk assessments, quality assurance records, policies and procedures. Following the onsite visits, we continued to review documentation remotely and received feedback from 5 professionals.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
•People were not consistently safeguarded from abuse and avoidable harm.
•People were not always protected from the risk of abuse and avoidable harm. The provider had a safeguarding policy and procedure, but this was not always followed. We saw multiple incidents not identified or reported as potential safeguarding concerns. For example, following an incident where 1 person was assaulted, the provider failed to report to the relevant agencies and safeguard the person effectively. We asked the registered manager to submit notifications for these incidents and raised our concerns with the local safeguarding authority.
•The provider did not always take sufficient action to safeguard people following allegations of abuse. For example, when a person had reported an allegation of abuse against a staff member, they were still permitted to work with the person on a 1:1 basis and an Thorough investigation into the incident had not taken place. This exposed the person and others to a risk of harm.
•The provider didn't always take sufficient action to protect people from self-neglect and harm. The provider had a medication policy and procedure in place, but this wasn't always followed. For example, the medicine policy stated, "A service user has the right to refuse medication and such refusal should be recorded. All such incidents should then be referred back to the prescriber, the service user's GP and/or nurse, or community pharmacist." The registered manager told us that they would report self-neglect and harm after 3 consecutive days but was not able to explain who had advised this was the appropriate time scale to escalate concerns to the relevant agency.
•The Registered manager didn't understand the legislation of the use of emergency physical interventions, for example following an incident where a person had physically assaulted a member of staff, the person's risk assessment and care plan did not detail how the person should be supported in the event of further similar incidents. The registered manager told us that they didn't think there was any situation where it would be appropriate to use an emergency physical intervention even if there was imminent risk of a serious injury to the person. This increases the risk of people not feeling safe and protected from abuse.

The failure to safeguard people from abuse and improper treatment was a breach of regulation 13 of the Health and Social care act 2008 (regulated activities) Regulations 2014

•Some of the people who use the service, told us that they didn't always feel safe, but they knew how to raise concerns and make complaints.
•The registered manager was responsive when we raised concerns.

Assessing risk, safety monitoring and management
The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks.
•The Provider had a risk assessment policy and procedure in place to support staff to identify and mitigate risks to people. However, this was not always followed.
•People's risk assessments did not have enough information to guide staff on how to support people safely. One person's risk and behaviour support plan included unclear and out of date information and the actions staff should take were confusing.
•The provider had not always updated risk assessments following incidents. For example, a person had a risk assessment in place for alcohol and drug misuse, however, this had not been reviewed or updated following an incident.

Using medicines safely
People were not always supported to receive their medicines safely.
• Staff did not always ensure medicines were administered in accordance with the providers medication policy. For example, between 9 October 2023 and 19 October 2023, there were 7 occasions where red crosses were entered on one person's medicine administration record, with no explanation of what this meant or why this medicine has not been administered, this had not been reported immediately. Another example, between 9 October 2023 and 19 October 2023 there were 20 occasions recorded on a person's medication administration record as refused and destroyed, this had not been reported immediately and the prescriber was not informed.

Staff not always assessing risks and the failure to operate safe systems and processes to administer peoples medication safely was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment

•Staff received training and were assessed as competent before they were able to administer medicines. Staff said that they felt confident to complete this task.
•Medicines were stored safely. For example, staff monitored the daily temperature of the medicines cabinet which ensured medicines were stored in line with manufacturers guidance

Staffing and recruitment
The provider ensured there were sufficient numbers of suitable staff. □
•Staff told us they felt there were always enough staff on shift, and they all work together to cover the shift.
•People we spoke with said the staff team is consistent and know them well.

The provider did not always operate safe recruitment processes.
•The provider had not ensured all appropriate checks had been completed to aid safe recruitment decisions.

• This meant the provider could not ensure staff were suitable to work in social care.
The provider failed to follow their own systems to ensure that staff were recruited safely. For example, we saw 5 staff recruitment files, the provider did not have full employment histories for 4 staff, did not have interview records for 4 staff, some staff had not had their identity checked and did not have current photographs. Some staff started work before having an enhanced DBS in place and there was no risk assessment on place. •The registered manager was responsive during the inspection and followed up on the

missing information. We have not been able to test whether these actions have been embedded. The provider and registered manager had not identified these shortfalls as part of their quality assurance systems.

Learning lessons when things go wrong
The provider did not learn lessons when things had gone wrong. Incidents had not been properly investigated with the learning outcomes identified or shared.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)
The provider was working in line with the Mental Capacity Act.

•Staff were able to explain the 5 principles of the Mental Capacity Act and what this meant to them. People told us that they could make every day choices. We found there were concerns with the recording of people's consent, our findings are further down the report under well-led.

Preventing and controlling infection
• People were protected from the risk of infection as staff were following safe infection prevention and control practices.
• The provider's infection prevention and control policy was written in line with current best practice guidance.
• We observed staff wearing appropriate PPE.
• There was a cleaning schedule in place and people were involved in keeping their home clean. • Professionals told us that the home was always clean.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

•The culture of the service did not reflect the principles of the statutory guidance Right Support, Right Care, Right Culture. The registered manager had not ensured people received person-centred support that promoted inclusion, choice, control, and independence maintained their dignity, and enabled them to have good access to local communities.
•We observed practice and saw records demonstrating that support was sometimes provided for service ease rather than to promote choice, independence and develop people's skills. For example, although people had been assessed as being able to take their own medicines, they were required to go to the office to receive their medicines from staff. The registered manager told us that this was their process. There was no evidence available of people's involvement in this decision.
•We saw records which recorded incidents of poor, inappropriate and controlling interactions between staff and people. For example, in one person's daily notes a staff member had written the person would have all their freedom taken away if they didn't follow some simple rules. This was not a factual statement for the staff member to make and placed people at risk of feeling disempowered and unsafe.
• There was no evidence of that people's long-term goals and associated skills development had been clearly established. People we spoke with did not know the skills they needed to develop to enable them to move into more independent living.
•People did not have their own key to the front door of their home, although they did hold the key to their bedroom door. The registered manager told us that people frequently lost their keys, but they could have one if they asked. The provider had not considered alternatives that would allow people independent access to their home without compromising security and safety.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and staff were not always involved in the running of the service and their protected characteristics were not always well understood.
•The provider sometimes failed to provide dignified support which respected people. For example, people's preferred names and pronouns were not always used during interactions with staff and throughout people's documentation.
•The provider was not always able to demonstrate how people were involved in decisions relating to their care or the running of the home. For example, the home held resident's meetings which people were invited

to attend. However, if a person did not wish to attend, or were unable to attend, we saw evidence of decisions being made for the person without their involvement or consent. The notes from the meeting recorded what had been discussed and any decisions made.
•The provider did not always listen to people when they made suggestions. For example, a professional told us, "I have been in meetings and witnessed staff not listening to [person's name]. When [person's name] says I want to try this… staff/ registered manager response is we have already tried that. There is not any further conversation or exploration as to how it may be adapted and may work now."

Working in partnership with others
The provider did not always work in partnership with others.

•The provider did not always act in people's best interest and involve the relevant professionals. For example, when people neglected themselves by not eating a nutritious diet and lost weight, this information was not always shared with the relevant health professional.
•We received feedback from health and social care professionals that it was sometimes difficult to gain information from the provider in a timely way.

The failure to provide person centred care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. person centred care.

•Despite the concerns identified we spoke with some staff who were very passionate. They knew people well and were able to describe in detail the progress that they had made towards independent living and the people who were ready to move out. A staff member told us, "When they stop speaking about staff supporting them in their new home to do things but talking about what they will be doing/need to do, they are ready to move on."
•People told us that staff treat them with dignity, respect and maintain their privacy. One person told us, "Staff always knock on my door before coming in."
•People had keyworkers who knew them well. they spent one day each week with their keyworker and had keyworker meetings. People were very positive about their keyworker and said they were able to support them and keep them updated with information. People said they felt confident raising concerns to staff, their key worker, and the registered manager.
•Professionals told us the provider was very open and honest and acted on issues raised.
•There was a reward scheme in place, people have chosen tasks they wish to complete each week.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements.
•The provider did not have an effective management structure. The provider did not monitor the quality of care provided in order to drive improvements.
•The provider's quality assurance processes were not effective, and had not identified the concerns we found during the inspection. The provider had insufficient oversight of the service. There was no evidence of quality monitoring processes and the provider did not have an action plan in place to help drive improvements.
•Records were not always detailed enough to keep people safe. Peoples risk assessments were unclear, did not identify known risks and did not provide detail of how the person would like to be supported to reduce the risk of harm. Peoples' care plans lacked detail which led to inconsistency in support being provided.
•The provider did not have an effective process in place to review accidents and incidents. The provider missed the opportunity to learn from incidents and put things in place to mitigate the risk of future similar incidents. There was not any documentation to evidence the support people and staff received following incidents.

• People were not always supported to receive their medicines safely.
• The provider did not always ensure medicines were administered and managed in accordance with the prescriber's instructions.

• People had the mental capacity to decide if they wished to take their medicines. However, this was not always monitored by the provider and there were no clear guidelines in place for staff in how people would like to be supported with their medicines.
• The provider did not ensure that CQC were notified of all significant events, in line with regulatory requirements. For example, we found multiple allegations of abuse, instances where police were involved in incidents and potential safeguarding concerns had not been reported. Following the inspection, the registered manager submitted retrospective notifications.
• The provider failed to follow their own systems to ensure that staff were recruited safely. •The provider had not included the frequency of staff supervisions in their policy. However, staff told us that they did have regular supervisions with the registered manager and this was usually every 6 weeks. the team knew people well and it was a small team which meant there was ample opportunity throughout each shift to have discussions.
•The provider has failed to ensure that staff were suitably trained to complete their roles safely. For example, some staff had not completed essential training such as health and safety, fire safety awareness, COSHH awareness, basic food safety, infection control, legionella and GDPR. The provider had no risk assessments in place or implemented control measures to reduce the risks.
•The provider had not ensured they had gained consent from people or that people understood what they were consenting to. For example, the provider used CCTV to monitor the shared areas of the home. The consent form failed to provide details of who had access to the CCTV recordings, and in what situations these will be viewed. The registered manager said people were verbally provided with information by staff.

The failure to have effective systems to assess and monitor the quality and safety of the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

•Staff told us they felt supported by the registered manager. One staff member told us, "We can talk to our manager if needed".
•People and staff were positive about the registered manager and the provider. For example, a staff member told us "If I've got a problem the manager will listen and take action or explain why she can't do it, anything you say to her she will help".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider understood their responsibilities under the duty of candour.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had shortfalls providing support in line with right support, right care and right culture and dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had shortfalls in providing safe care and treatment

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people from abuse and self neglect

The enforcement action we took:

we issued a warning notice against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient oversight of the service and ensured the service was running safely

The enforcement action we took:

warning notice against the provider