Care Quality Commission

Rehabilitation Education And Community Homes Limited

Reach Magnolia

Inspection report

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Date of inspection visit:
11 October 2022
12 October 2022
17 October 2022

Date of publication:
30 November 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Reach Magnolia is a residential care home providing the regulated activity Accommodation for persons who require nursing or personal care to up to six people. The service provides support to people with a learning disability and autism. At the time of our inspection there were six people using the service.

Reach Magnolia accommodates four people in the main house and two people are accommodated in the annex at the rear of the property.

People's experience of using this service and what we found
Relatives had mixed feedback on the service. Some relatives told us the care had improved under the new registered manager with better access to activities, and they had tried hard to recruit new staff into the vacant positions. Other relatives felt improvements were still necessary to enable their family member to have the required level of supervision and support from a more consistent and suitably trained staff team.

Safe medicine practices were not promoted and risks to people were not identified and mitigated. Alongside this, some staff practice did not mitigate infection control risks.

The required staffing levels were not always provided which impacted on the level of supervision and support people received, including community access. Staff were inducted, but not suitably trained and supervised in their roles to benefit people.

Records were not accurate and suitably maintained. Auditing was taking place. However, this was not carried out in line with the provider's procedure and failed to identify the shortfalls we found.

Systems were in place to safely recruit staff. However, staff recruitment files did not contain evidence of actions taken in respect of chasing references or fully mitigate risks around any potential convictions. We have made a recommendation to address this.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Model of Care and setting that maximises people's choice, control and independence. 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.

Right Care: The provider was committed to promoting people's dignity, privacy and human rights. They had identified a dignity champion and a dignity tree was on display which outlined how this was achieved. However, we observed during the inspection terms of endearment was used when engaging with people, a person was referred to as a "Good boy" and another person was told to "Chop, chop" when being supported to leave the service. These interactions did not promote people's dignity and human rights.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives. The provider was proactive in promoting a positive culture within the service. Poor practice was addressed, and some staff had specific training provided to further improve their practice and interactions with people.

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 6 June 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

In response to a review of the information we held about this service, we undertook a focused inspection to review the key questions of safe, effective 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 requires improvement based on the findings of this inspection.

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

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

We have identified breaches in relation to safe care and treatment, medicine practices, staffing, the application of the Mental Capacity Act 2005 and good governance.

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

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

Care Quality Commission

Reach Magnolia

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.

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

Inspection team
The inspection was carried out by one inspector on site over three days, with an Expert by Experience involved in making calls to relatives after the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Reach Magnolia 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. Reach Magnolia 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:

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last 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 used all this information to plan our inspection.

During the inspection
We walked around the service to review the environment people lived in. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, operations manager, assistant operations director, deputy manager, a team leader and two support workers. We reviewed a number of records relating to individual's care and the running of the service. These included support plans for three people, medicine records for six people, three staff recruitment files, fire safety, health and safety, audits and staff competency assessments.

We asked the provider to send further documents after the inspection for review, which included policies, training matrix, supervision records, provider audits and meeting minutes. We spoke with five relatives, three support staff and sought feedback from professionals involved with the service.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
● Risks management was not effective in mitigating risks to people. Risks for one person around eating had not been identified and mitigated. As a result, we saw the person eating quickly and putting excess food in their mouth. This had the potential to put the person at risk of choking. The staff member attempted to get them to slow down whilst eating, which they were unable to do. The staff member then made the decision to feed the person, which did not promote their independence. The support guidance in place on nutrition and hydration indicated the person was independent when eating and the risk assessment for hydration and nutrition indicated they were not a risk of choking, which was not as we observed. The registered manager told us the person's needs had changed however, the service had not identified the risks around eating until we brought it to their attention.
● A person was prescribed emergency medicine to be used in the event of a seizure. A health professional had provided guidance on its use. However, the guidance was not included in the person's care plan on managing the person's epilepsy or the risk assessment on the epilepsy. One of the recommendations of the specialist health professional was the emergency medicine should be taken out with staff when the person went out in the community. The registered manager told us staff take it with them. However, staff confirmed they were not aware they needed too and had not been, which had the potential to put the person at risk.
● The service had a person who was prescribed an emollient cream. The emollient contained paraffin oils which are flammable. There was no risk assessment in place to identify and mitigate the risk and staff were not aware the cream was flammable. Another person smoked. A risk assessment was in place which indicated the person had a cigarette every hour. However, there was no specific guidance around how that was managed to mitigate risks and to ensure a consistent approach.
● Risks of scalding from hot water were not mitigated. Monthly water temperatures checks were completed. The records from March to September 2022 showed six occasions where the water temperature was recorded as exceeding 44 degrees centigrade which is the recommended maximum temperature for hot water outlets. This was not noted or acted on.
● Fire safety risks were not identified. The service had an oil heater in use. The measures in place to mitigate the risk were not followed. We saw the oil heater was next to a person's bed as opposed to situated against the wall as was outlined in the risk assessment. Alongside, this the night-time fire drill record showed more staff were involved in the fire drill than would be available in the event of a fire at night. Therefore, despite regular fire drills taking place the provider had not assured themselves that two staff could safely evacuate people at night.

Risk management was not effective to promote 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.

● Other risks to people were identified and mitigated, such as risks associated with personal care, life skills and community access. Guidance was provided on how risks around episodes of distress were to be managed. These included primary and secondary preventative intervention to prevent escalation.
● Health and safety checks took place which included fire safety, first aid boxes, water temperature, window restrictors and checks of equipment such as mattresses and sensor mats. Legionella testing was completed in September 2021 and equipment such as gas, electricity and fire equipment were serviced. A fire risk assessment was in place dated January 2019 and reviewed annually. People had personal emergency evacuation plans (PEEPs) in place and monthly fire drills took place to promote fire safety.

Using medicines safely
● Safe medicine practices were not promoted. The provider's medicine policy indicated protocols would be in place for "as required" medicines. The protocol would outline the name of the drug, route, dose, frequency, time between doses, maximum doses in 24 hours, when to administer and a review date. For two people protocols were not in place for "as required" PRN Lorazepam. For one person, there was conflicting instructions in various records within their care plan, as to why the PRN Lorazepam was to be given. For example, as a last resort for managing behaviours that challenge, depression and to be used for procedures such as vaccinations. For the second person, there was no guidance around the "as required" Lorazepam. We saw both people had Lorazepam administered on the 26 September 2022 prior to their Covid -19 booster, without any guidance to indicate this is what the medicine was prescribed for.
● Accurate records of current medicines were not suitably maintained which meant medicines were in stock, which were not on the medicine record. Where medicine was discontinued it was not always outlined when or why. This had the potential to put people at risk of being administered medicine no longer prescribed for them.
● The provider's medicine administration policy outlined how medicine out of the service were to be managed. It indicated "On occasions, where the people we support leave the service to visit family or friends for a period of time that requires medication to be taken with them, staff should ensure that the whole packets or whole monitored dosage system are given to the family and that this is recorded on the medicine administration record(MAR). A copy of the MAR chart should also be given. The service kept a record of medicines taken out of the service for social leave. This was not recorded on the medicine administration record. The record maintained did not match the medicines prescribed on their medicine record. For example, we saw a person was given temazepam to take on social leave. Whilst this was not administered by the family it was not recorded, on the person's medicine administration record as prescribed. Therefore, the service was not working to its own medicine administration policy or to best practice in medicine administration. No guidance was provided on recording medicine returned following social leave. As a result, no record was maintained by the service of medicines returned to ensure accurate stock checks of medicine or to assure themselves that medicine was given as prescribed, whilst on social leave.
● A person was prescribed a topical cream. There was no guidance as to where that was to be applied, other than apply to affected areas. There was no topical administration chart in use to outline what those affected areas were.

Proper and safe management of medicines was not promoted. 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 suitably stored and at the recommended temperature. A record was maintained of medicines ordered, received, administered and disposed of.
● Staff involved in medicine administration were trained in medicine administration. Medicine competency assessments were carried out to assess if staff were suitably skilled in the task. These were reviewed annually or in response to a medicine error.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. On arrival at the inspection on day one, we saw the two staff members in the minibus with three people were not wearing face protection. This had the potential to put people at risk of cross infection. Other staff were observed wearing a mask in the service.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The providers infection control policy outlined "Nails should be short and clean – no nail polish or extensions." We saw a staff member had long painted nails. This was not in line with the providers policy and did not mitigate the risks of cross infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
Family visits to the service were taking place and people were able to go on social leave if they wished.

Staffing and recruitment
●The registered manager confirmed staffing levels were provided in line with people's dependency levels. Two people required one to one staffing during the day and other people had delegated hours of one to one support or two to one in the community.
● We were told five staff were provided on the daytime shifts, with a mid-shift staff member provided to enable community activities to take place. A waking night and sleep in staff member were available at night. The rotas viewed showed the staffing levels required were not always maintained with only four staff regularly provided on the day shift. Whilst the staffing risk assessment indicated a safe service could be provided with four staff on the daytime shifts, this impacted on people's community access. During the inspection we saw a person had to wait for a staff member to be available to take them out for a walk, whilst another person who required one to one support was left unsupervised for periods of time after lunch.
● The rotas showed staff worked a mix of long days, early and sleep in shifts. Guidance was in place around the number of hours/ shifts staff should work each week. An agency staff member regularly worked a minimum of five long days a week which was not in line with the providers guidance on the working time directive. Another staff member worked long days, followed by sleep in shifts in succession. For example, in one week they worked three sleep in's and two long days in succession.
● Some staff felt the staffing levels were sufficient, whilst other staff told us they felt there should be more staff due to a change in need of a person they supported and to consistently be able to take people out for activities.
● Relatives felt there was a high turnover of staff with regular new faces supporting their family member, whom did not have a relationship with them.

Sufficient staff were not provided to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives felt there was not sufficient management cover at the weekends and whilst they were informed when short staffed this impacted on community activities for their family member. The rota's reviewed over a three-week period showed the deputy manager worked two out of those three weekends and this was their normal pattern of work. This ensured management cover was available at the weekends with on call management support also available.

● Systems were in place to promote safe recruitment practices. Staff completed an application form, attended for interview and completed a written task. If they were successful at that stage, they were invited to the service to enable the people who used the service to give feedback on them and enable the candidate to gain insight into the role. Completed health questionnaires were on file and gaps in work histories were explored.
● A minimum of two references were on file. However, in two staff files viewed a staff member's two references were from the same employer. This was noted but no further action taken. In the other staff file a reference was not on file from a previous employer they had worked for the longest. A third character reference was obtained. The provider confirmed a reference had been sought from that employer. However, there was no record on file to support that. They agreed to provide evidence on file of the actions taken.
● Disclosure and Barring Service (DBS) checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Where a conviction had been highlighted; a risk assessment was completed to support the rationale for employing the staff member. However, the risk assessment did not address fully the convictions outlined. The registered manager agreed to review and update the risk assessment.

It is recommended the provider works to best practice and their own recruitment policy to ensure staff are safely recruited.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to safeguard people. The provider had safeguarding policies in place and 88% of staff had completed on-line safeguarding training. Staff spoken with were aware of their responsibilities to report safeguarding concerns. Staff commented "If I witnessed abuse, I would stop it and report to the manager to agree on actions," and "I would confront and report."
● Some relatives felt their family member was safe and got the required support to keep them safe. Other relatives gave examples where their family member did not get the level of supervision required which impacted on their family member's safety. This was feedback to the registered manager to be aware of and address.

Learning lessons when things go wrong
●Accident and incidents reports were reviewed and signed off by the registered manager. Records were maintained of accident and incidents to enable them to pick up trends and respond to those. The operations director told us debriefing takes place after an incident to promote learning. However, a record was not maintained of the debrief of a recent incident or included as part of the accident / incident form. The registered manager agreed to address that.

Requires Improvement

Is the service effective?

Our findings

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

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

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

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The registered manager lacked an understanding of the application of the MCA. Therefore, people did not have MCA's in place in relation to all aspects of their care, which they did not have the capacity to consent to.
● Two people's MCA's and best interest decision record with regard to the administration of the Covid-19 vaccination and booster were completed when people were first vaccinated in 2021 and not when they had their recent booster. Both people needed "as required" Lorazepam to have the booster vaccination and we saw this was administered. However, the MCA and best interest decision on Covid-19 vaccinations/booster made no reference to it and the decision to give "as required" medicine for such a procedure was not recorded as a best interest decision.
● A person took their medicines with food. There was an MCA and best interest decision regarding medicine administration. However, this made no reference to them taking their medicine with food.
● The registered manager had consented to the flu vaccine on behalf of people. This decision was not made as part of a mental capacity and best interest decision, which is not in line with MCA 2005.

People were not consented with on all aspects of their care. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff were not suitably skilled and trained for their roles. The training records viewed showed no staff had Management of Actual and Potential Aggression (MAPA) training, which was deemed mandatory by the provider for the service, as the service supported people with distressed behaviours. During the inspection we observed staff were not consistent in how they managed situations when a person became distressed.
● A staff member in post since February 2021 did not have learning disability or communication passport training. A second staff member in post since October 2021 did not have Anaphylaxis Awareness training even though this was required for the service. A third staff member in post since October 2021, moving and handling training had expired in September 2021 and communication passport training was not completed. The provider confirmed in response to the draft inspection report that two of those staff members were relief staff whom, had ceased employment with them. However, one of those staff had worked up until October 2022 without the required training.
● The registered manager had completed a Level 5 National Vocational Qualification in management. However, other training such as the Mental Capacity Act training was on-line, and this training was not understood or embedded in practice. The registered manager and deputy manager had no other specific management training to support them in their role such as in auditing, staff performance issues and supervisions.
● Staff told us they felt suitably supported and had one to one supervision, with the registered manager or deputy manager. The providers policy on support and supervision outlined that all staff should receive a formal supervision meeting with their line Manager at least every 4 to 6 weeks. A supervision matrix was in place which showed variances in the frequency and type of supervision. One staff member had no formal supervisions recorded and only had monthly observations of their practice carried out. Other staff were not having supervision at the frequency outlined, with some staff having more than 8 weeks between supervisions. There was no supervision recorded on the supervision matrix for the registered manager. They confirmed they had a supervision in July and the supervision scheduled for September was cancelled due to annual leave.

Staff were not suitably trained, skilled and supported in their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff completed an induction into the home and initially worked shadowing shifts alongside other staff. They were working through the Care Certificate training. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. Despite the gaps in the training matrix the staff told us access to training was good, with regular updates provided.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Systems were in place to ensure people were assessed and that they were compatible with people already living at the service. Their preferences, religion, cultural and diverse needs were identified and met. Staff were trained in equality and diversity to enable them to support people effectively.

Supporting people to eat and drink enough to maintain a balanced diet
● People's support plans outlined their nutritional and hydration needs, although we saw for one person this was not up to date to reflect the actual support and intervention they required. This was addressed by day two of the inspection and revised guidance agreed.
● People's weights were monitored, and action taken in response to weight loss and weight gain. Records were maintained of meals eaten and drinks taken.

● Pictures were used to enable and encourage people to choose their meals. Relatives gave us mixed feedback on the meals provided. Some relatives felt the food provided was good and their family members was offered choices. Other relatives felt the menu was improving but lacked variety and healthy options were not consistently encouraged.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
●People had health action plans in place which outlined the support required to meet their health needs. People had access to health professionals and a record was maintained of the outcome of appointments and actions.
● Individuals had hospital passports in place to ensure consistent and effective care if admitted to hospital.
● Relatives were generally happy that their family members health needs were met, and medical appointments took place. One relative told us their family member did not have regular medical reviews. This was feedback to the registered manager to follow up on. In response to the draft inspection report the provider confirmed two medical reviews for the individual had taken place in 2022.

Adapting service, design, decoration to meet people's needs
● The service had a refurbishment plan in place. It indicated when major improvements were scheduled. We saw some areas of the home had been decorated and updated. The carpets throughout the home were in need of replacement and these were scheduled to be replaced in November 2022. The driveway at the front of the property was damaged by the roots of a neighbouring tree. Immediate actions had been taken to mitigate further damage and plans were underway to repair the driveway.

Requires Improvement

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 Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Records were not accurate and suitably maintained. People's files were contradictory. In one person's file it indicated they needed to be observed whilst having a bath. Within the epilepsy care plan, it indicated they did not require a staff member in the bathroom with them and the staff member must remain outside the door. In another person's file the guidance on epilepsy indicated the person required 15-minute checks. In the physical health guidance, it indicated the person should be checked every 30 minutes. The same person's guidance on eating indicated they were independent when eating and did not require their food to be cut up. The health action plan indicated the food was to be cut into bite size pieces.
- Changes made to people's care plans following reviews were handwritten and illegible. For one person, following the update to their care plan it was not clear if they were required to continue with a supplement drink or not, to mitigate nutrition risks.
- Other records relating to the running of the service were contradictory such as different guidance in records around the recommended safe water temperatures and no guidance was provided on what were safe temperatures for fridges and freezers.
- The rota was illegible in parts, due to changes. Where there were gaps in the rota the registered manager told us, they assisted on shift. However, this was not reflected on the rota. Some people went on social leave with family members. This was not consistently recorded on the rota to support the rationale for less staff on shift.
- Other records were generally disorganised, with gaps in recording and not dated. Not all staff had read to confirm they had read guidance on how they support people or relevant guidance to ensure they had the knowledge to mitigate risks to people.
- Systems were in place to audit the service. The registered manager completed a series of in- house audits, which included medicine audits. A health and safety staff member carried out health and safety audits. These audits had not identified the issues we found with medicine practices and water temperatures. The providers internal auditing systems policy outlined Operation Managers carry out a themed audit at each service on a monthly basis. However, provider monthly audits were not carried out and not all of the provider audits outlined on the schedule were completed such as audits of safeguarding, complaints, and medicines.
- Throughout the inspection we observed a staff member used terms of endearment such as "Darling, love, sweetheart," when engaging with people. They regularly referred to a person as a "Good boy" and told another person to "Chop, chop" whilst attempting to get them out of the home. Another staff member was observed not engaging with a person at mealtime and was instead writing up daily records. These practices

did not promote a positive culture within the service to achieve positive outcomes for people.

Records were not suitably maintained, and effective systems were not in place to monitor the service and provide positive outcomes for people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager was committed to the role and the people they supported. However, they lacked the knowledge and training of some aspects of the role, with minimal support and opportunity provided by the provider to develop in the role.They had a new staff team they were developing and supporting, including working alongside them and covering shifts which impacted on their ability and time to manage the service.
- The registered manager was aware of what needed reporting to CQC, and the required notifications were made, in a timely manner.
- Staff felt the service was well managed and that the registered manager had brought positive changes to the service. The registered manager was described as "Approachable, kind, caring, good listener, strong and strict, but in a kind way." Staff commented "The quality of management is good, the manager is responsive to staff and people and she tackles issues in a professional manner," and "The manager listens, operates an open door, issues can be raised and addressed. They help out on shift and are always ready to participate."
- Relatives felt the registered manager had brought positive changes to the service. They commented "[Registered manager's name] communicates well and is a respectful, happy and lovely lady," and "The manager is very efficient and respectful to us". Another relative told us if something goes wrong, they are told it will be investigated. However, they commented "Nothing ever comes of it". The registered manager was made aware to ensure relatives are kept informed of outcomes of investigations that affect their family member.
- A professional involved with the service commented [Registered managers' name] is a 'visible' leader. She is accessible and responsive to advice from the Positive Partnerships Team and other clinicians within the Community Learning Disability Team."

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 had a duty of candour policy in place which was developed in line with regulation 20.
- Whilst no duty of candour incidents had occurred in the time under review, the registered manager was aware of their responsibilities in respect of a duty of candour incident.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems were in place to get feedback on the care provided. An annual survey of staff, people, relatives and professionals was carried out in March 2022. Feedback from the survey was analysed with actions in place to address the issues raised.
- Systems were in place to promote communication within the team. Handovers took place on each shift and a shift planner was in use which outlined tasks and activities for the shift. Monthly team meetings took place.
- Staff felt communication within the team and teamwork was good. New staff felt welcomed and supported. They commented "Communication is good, so we are kept up to date and we all work as a team and help each other out."
- Relatives generally felt communication with them was improving. They commented "I can reach the team

via email and use social media platforms such as WhatsApp as an alternative," and "I can see the manager face to face in the office and their e-mails response rate is good and efficient."

Continuous learning and improving care. Working in partnership with others

- The registered manager was committed to improving care for people. They took on board our feedback to bring about improvements. On day three of the inspection they had acted on our initial feedback provided.
- Staff were being developed in roles and champion roles were identified such as infection control and dignity champion. A health professional told us they had worked with the service in improving outcomes for people. They commented" We have delivered training to the staff team in Understanding and Responding to Autism (SPELL Framework). Over our time working with the registered manager and the staff team we have found them receptive to learning, enthusiastic and eager to implement changes to the practice that will enhance the quality of life of service users. They have proactively applied learning to practice and service users are better understood, have more choice, autonomy and engagement in meaningful activities and relationships."
- The service liaised with health professionals involved in people's care. A professional commented "Communication with the home has been very good. [The registered manager's name] has a good understanding of the people they support and their needs. She is proactive and caring."

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 11 HSCA RA Regulations 2014 Need for consent People were not consented with on all aspects of their care in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk management was not effective to promote safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance was not established which resulted in records not been suitably maintained and monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staffing was not provided and staff were not suitably trained and supported,