Gian Healthcare Ltd

14 Thornholme Close

Inspection report

14 Thornholme Close
Manchester
M18 7RL

Date of inspection visit:
31 March 2022

Date of publication:
07 July 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
14 Thornholme Close is a care home and provides accommodation and personal care for up to two people who have a range of needs including autism, mental health needs and/or learning disabilities. There was one person using the service at the time of this inspection.

People's experience of using this service and what we found
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 the Care Quality Commission follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support
Staff attempted to support people with activities they liked, however these were limited due to the constraints of the support and environment. The service didn't always escalate incidents to the safeguarding team, when people experienced distress. Staff and managers failed to learn from incidents and how they might be avoided or reduced. The service design of the home did not always promote strategies to enhance people's independence or reduce anxieties. People receiving support only had access to the bathroom, their bedroom and lounge.

Right Care
The service did not have appropriately skilled staff to meet people's needs and keep them safe. Staff had not be trained to fully understand people they were supporting. People had individual ways of communicating such as using body language, sounds, Makaton (a form of sign language), pictures and symbols. However, we found not all staff had the necessary skills to understand how to interact with people. Relatives told us they were concerned about people's health and wellbeing at this service due to the staff not having the necessary skills to support people with autism.

Right culture
People could not be assured the culture at the service was inclusive and empowered lives. This service stated within their statement of purpose they could meet a number of needs, however we found this was not the case. The service could not assure us that there wasn't a closed culture, as there was a lack of oversight and over reliance on agency staff. The provider's monitoring and oversight processes were not effective and had not identified the substantial shortfalls we identified during our inspection.

The provider/staff had not always identified incidents as safeguarding concerns and had not appropriately

reported safeguarding concerns to the local authority. This placed people at risk of not having safe care and treatment.

There was a lack of provider and managerial oversight of the service. There was a failure by the provider to ensure robust governance arrangements were in place to monitor the safety and quality of the service. Shortfalls across the service such as poor staff provision, lack of oversight of accidents and incidents and limited oversight of safeguarding had not been identified prior to our inspection. These failings resulted in multiple breaches of regulation.

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

Rating at last inspection and update
This service was registered with us on 22 July 2019 and this is the first inspection.

Why we inspected
This was the first inspection of a newly registered 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.

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 person-centred care, dignity and respect, safe care and treatment.

Full information about CQC's regulatory response to more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
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**

14 Thornholme Close

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector.

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

This service is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 31 March 2022 and ended on 19 April 2022.

What we did before inspection
Before the inspection we reviewed the information we held about the service and the service provider. We sought feedback from the local authority and professionals who work with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our 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.

During the inspection
People living at the service were unable to communicate with us due to their level of need. We therefore spoke with relatives. We spoke with four staff members, this included the director, care coordinator, one nurse and one support worker.

We reviewed a range of records. This included people's risk assessments, support plans and two staff files in relation to recruitment. We also reviewed records related to the management of the service, which included incident reports and safety records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who were involved in the emergency placement for the person receiving a service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment; Assessing risk, safety monitoring and management

- The service did not have enough skilled employed staff to meet people's assessed needs and there was an overreliance on agency staff to deliver care.
- The provider did not have any staff employed at this service to deliver bespoke care to people. Agency staff included an agency nurse commissioned by Clinical Commissioning Group (CCG) who worked with this person.
- There was a poor culture and working environment. The provider had not risk assessed the impact of agency staff working prolonged long hours, particularly with people who have complex needs. One agency staff member had worked consecutively for six days equalling approximately 80 hours.
- The provider completed an environmental assessment, however people were not always protected from risks found in the home environment. In one room a large, mirrored wardrobe posed a risk to people, due to certain behaviours they expressed. The wardrobe had also been identified by external professionals several weeks before our inspection, but this risk had not been acted upon by the provider. The provider removed this mirrored glass panel shortly after the inspection.
- One family member told us they had expressed concerns about a broken radiator cover with exposed nails in their relatives room. The family member asked the nurse to remove this, which they did.

Systems had not been established to assess, monitor and mitigate risks. Furthermore, staff did not have the necessary qualifications, competence, skills and experience to deliver this service safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The person's care plan included guidance for staff on the management of risk, in the way of a positive behavioural support plan. Following our inspection, a learning disability nurse from the CCG attended the service and made recommendations for the provider to update the care plan with details of support required.
- The provider's recruitment practices were safe. Necessary pre-employment checks had been completed for new permanent staff to ensure they were suitable for employment in the care sector.
- The provider had arrangements for the ongoing maintenance of the premises. This included checks for fire, gas and electrical safety.

Systems and processes to safeguard people from the risk of abuse

- Systems for identifying and reporting safeguarding concerns were not effective. The provider's failure to identify and act upon safeguarding incidents exposed people to the risk of harm. We identified a near miss where a person ran away from their school transport bus and staff had to run after the person. This incident

had not been reported to safeguarding, given the person's vulnerability in the community and unfamiliar surroundings this matter exposed the person to risk.
● We reviewed six incident reports. We found the entries recorded within these incidents discriminated people on the grounds of any protected characteristics (as defined in Section 4 of the Equality Act 2010). We noted entries recorded from staff included, "[Person's name] was kicking off," "Attacking staff," and "[person's name] has been naughty they won't be going outside." There was a lack of understanding and empathy towards autistic people.

Systems and processes had not been established or operated effectively to protect people using the service from the risk of abuse or neglect. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Given the concerns we identified about this service, we raised a safeguarding referral with the local safeguarding team and shared our concerns with the local CCG.

Learning lessons when things go wrong
● Lessons were not learnt from accidents and incidents. Care plan and risk assessment reviews did not include information from recent accidents or incidents. This meant it was difficult for staff to learn from them and increased the risk of them happening again.
● 'Debrief sessions' were prompted on serious incident reports but discussions did not take place following serious incidents and therefore staff did not learn from them. Following the inspection, we received information indicating de-briefs had taken place for three of the six incidents.

Preventing and controlling infection
● When we arrived two staff were not wearing face masks in line with guidance. We informed the staff of this and the masks were then worn. Other staff, including the director, nurse and care co-ordinator, wore the appropriate PPE.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
●The service supported visits for people living at the home in line with current government guidance.

Using medicines safely
● People were not prescribed medicines at the time of our inspection. However, we found a medicines cabinet was installed in the lounge, this would not be appropriate and had not been risk assessed. We discussed the safe storage of medicines with the provider, who agreed they would re-locate the medicines cabinet in a room that was secure within the home.

Inadequate

Is the service effective?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The skills of staff did not always match the needs of people using the service. People were predominately supported by agency staff who had not received consistent guidance or training to support people with a learning disability or autistic people.
- People receiving the service would at times be distressed or agitated, but we found no training available or completed for the majority of agency staff. This meant staff were not adequately equipped to ensure they could meet people's needs.
- The service did not have an effective system to check agency staff's competency to ensure they were skilled and experienced to safely support people. Incidents we reviewed indicated a lack of experience within the staff team.
- The majority of agency staff working at the service had not received training for people's communication needs. For example, staff had not been trained in Makaton or the use of picture exchange communication system (PECS) and communication aids, although people used these methods of communication.
- The service was not registered to provide nursing care. However, the provider had accepted a care package for a person who was supported by agency nurses on a daily basis. The provider didn't have oversight of the nursing staff being deployed or knowledge of their competencies. This meant there was no systematic approach at provider level to determine whether the staff working with the person had the appropriate skills.

The provider failed to ensure staff received appropriate training and support to enable them 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.

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

- The property was not suitable for the care and treatment provided. The layout of the bungalow was not big enough to accommodate people's needs.
- The environment did not offer people the necessary space when they became distressed or agitated towards staff, to allow the person time and space alone to calm down. Following our inspection, a CHC nurse attended the property and made several recommendations, one being, to make property look more homely and inviting.
- The provider completed an environmental risk assessment prior to people moving in. This assessment was limited and failed to consider people's preferences to ensure the environment was suitable to meet their needs. We found a medicines cabinet was stored in the lounge and a large glass mirrored wardrobe in the office, both potential risks were known to the provider, but had not been risk assessed.

● A family member was also concerned about the environment, they told us, "The small bungalow isn't safe for [person's name] the house is far too small for [person's name], I really worry for [person's name]." Due to the poor completion of the environmental risk assessment, people's needs, and preferences were not been taking into consideration to ensure the environment was suitable to meet their needs.

The provider failed to ensure the premises were suitable for people and risk assessed to ensure safe care and treatment could be delivered. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● The provider had failed to ensure assessments had been completed and this resulted in a lack of guidance for staff in how to support the person when they are distressed and presenting with behaviours which may challenge others. However, after our inspection we were provided with a risk assessment and mitigation plan that the provider states were available at the time of inspection for staff to follow.
● People didn't have their sensory support needs assessed by the provider. This meant potential adaptions to the environment had not been considered or adapted to meet people's sensory needs and reduce any negative impacts the environment may have had on people.
● The provider's pre-admission assessment for the person also made reference that staff are trained in Prevention & Management of Violence and Aggression (PMVA). However, we found this was not the case and the majority of the agency staff used had not received this training. This meant there was a risk untrained staff would not be equipped to manage untoward incidents.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to maintain a balanced diet and the service was following the person's dietary requirements.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Records confirmed capacity assessments had been completed by the provider. DoLS were applied for where appropriate.

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

● The provider worked with other agencies to enable people to receive effective care. Following our inspection, a CHC nurses visited the person to complete a review. A number of recommendations were made for the provider to implement, such as updating people's communication passport.

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We looked to see how the home sought to promote the principles of equality, diversity and human rights (EDHR). Through the issues identified during this inspection, it was evident these basic fundamental principles were not embedded into everyday practice across the home. Some of the agency staff training profiles we viewed indicated they had not been trained in equality and diversity.
- One relative we spoke with said, "I know [person's name] is not happy at the home. [Person's name] always wants to come back home with us when we visit, it's sad to see."
- Staff recognised the importance of building trust with people they supported. One support worker told us, "I am shadowing the other staff at the moment and learning how to support [person's name]."
- We received assurances from the CHC nurse who reviewed people at the home after we raised our concerns, they commented: "[Person's name] has now built up a rapport with the staff team and has settled reasonably well in the bungalow."
- People's rights to privacy and confidentiality were respected. Staff made sure that people's care records were stored securely.

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

- People's relatives were involved in decisions about the care provided. This included what people needed help with and how they liked care to be carried out. For example, one person's personal care routine needed to be completed in a particular order and staff ensured this was adhered to.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- The provider did not demonstrate how they were able to provide bespoke person-centred care to meet people's needs. We found people's support needs had not been appropriately assessed by the provider to determine whether the staff employed could meet their needs.
- The provider confirmed during the assessment stage, that the service was equipped to manage people expressing emotional distress; however, we found the provider was over reliant on the use of agency staff, with the majority of the agency staff not sufficiently trained to meet people's needs.
- The provider devised positive behaviour support plan (PBS). However, we found one person's PBS plan had conflicting information and the recent review undertaken by a CHC nurse. The NHS CHC review document made reference to staff being trained in Prevention & Management of Violence and Aggression (PMVA) and physical Intervention would be used as a last resort on the person, however this person's PBS made no reference to PMVA being used. There was a risk staff were not equipped or prepared to manage a serious incident involving the person.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Staff did not always follow guidance in people's communication plan. During the inspection we observed two staff members attempting to communicate one person, both staff appeared apprehensive and distanced themselves from the person. The person's preferred communication was limited Makaton and picture exchange communication system (PECS), however the service was not equipped to deliver this support to the person. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care.
- A further incident of staff not communicating clearly in line with people's communication needs, happened when a person's bus was late. At no point during the record of this incident did staff attempt to use the appropriate communication method to inform the person what was happening, this incident led to the person becoming distressed.

The provider failed to provide the person with personalised care which reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were able to maintain relationships with their family.

● People were able to maintain some structure in their life, with school provision taking place five days a week for one person. People also able to access a large secure garden at the service. The provider purchased a trampoline, and this worked well to reduce anxiety for the person at the service.

● People were able to maintain their relationships with family members. Arrangements were in place for the person's family to visit.

● People's care plan did consider their preferences, likes and dislikes. Daily records had been completed detailing the care and support people had received and activities they had engaged with.

Improving care quality in response to complaints or concerns

● The provider told us there were no complaints at the time of the inspection. There was a satisfactory complaints policy in place. No new concerns or intelligence had been received regarding the provider's complaint processes.

End of life care and support

● At the time of our inspection no one using the service was receiving end of life support.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- The provider and registered manager failed to operate effective systems and processes to manage risks to people's health and welfare and ensure the service was safe.
- The provider had not identified the widespread and significant shortfalls in the safety and quality of the service which had let to multiple breaches of regulation and placed people at risk of harm.
- People were at risk from the development of a closed culture. A closed culture is one where people's needs are not placed at the heart of care practices and people not being involved in their support. The provider and registered manager did not have oversight of staff practice or of the agency staff predominantly providing care and support. The provider was not aware agency staff had not received appropriate training for their roles and had not assessed the impact of agency staff working long hours and days for staff or the person they were supporting.
- The provider had failed to adequately review incidents and identify inappropriate terminology used by staff which demonstrated a lack of knowledge and expertise in caring for people with learning disabilities. For example, one incident described a person as being 'naughty'. Following our inspection, the provider introduced a communication form, which cited the correct terminology when documenting in care notes.

The failure to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We would expect providers of services for people with a learning disability and autistic people to demonstrate how they are complying with the principles of right support, right care, right culture guidance. In discussion with the provider and from our findings, we were not assured the service understood this key guidance. This increased the potential risk of people not receiving empowering care tailored to their needs.
- According to the provider's statement of purpose, they indicated they could deliver a wide range of services for people with complex needs, such as people with learning disabilities, own syndrome, Williams syndrome and autism. However, considering the shortfalls identified we were not assured the provider was meeting their statement of purpose and didn't have the necessary skilled workforce to deliver safe care and treatment.

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

- The service worked in partnership with other professionals and agencies to help ensure people received the health care they needed.
- Due to the limited size in service, the provider did not have the opportunity to complete questionnaires to gain feedback.
- After our inspection we were provided with minutes of three staff team meetings, where the provider discussed certain protocols with the agency staff.