Achieve Together Limited

42 Twyford Gardens

Inspection report

42 Twyford Gardens
Worthing
West Sussex
BN13 2NT

Tel: 01903263906
Website: www.achievetogether.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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.

About the service
42 Twyford Gardens is a residential care home providing personal care to three people, one of whom was in hospital at the time of the inspection. The service can support up to four people. The service was a detached bungalow with a garden, near to the town. People had their own bedrooms and bathrooms. There were shared eating and living areas.

People's experience of using this service and what we found

Right Support:
Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. People's medicine support was not being managed safely. People were not always supported to assess their needs effectively and did not always achieve good outcomes from their support. Staff had not always received effective training or supervision. The service was clean and hygienic.

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:
Staff did not always communicate or support people in dignified or respectful ways. Improvements were needed to make sure people were involved and included in a personalised way when being supported by staff. People told us staff were not always caring and did not always encourage them to be as independent as possible. Professionals who worked with staff and relatives of people at the service gave us mixed feedback about the quality and safety of the support people received.

Right Culture:
Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not operating effectively to identify or resolve issues.

People and their relatives said they did not always feel involved and engaged in planning their support or developing the service. Staff did not always feel supported to fulfil their roles and responsibilities. Staff and

people told us the culture of the service was negative and was not helping people to achieve good outcomes.

The provider was aware of quality and safety issues at the service. They had offered assurances about actions they would take and were committed to providing resources to make any necessary improvements as quickly as possible.

The provider had an Equality and Diversity Policy and the interim manager told us how it was important to them that they always promoted and respected staff equality and diversity as a leader within the provider's organisation.
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 9 March 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.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action 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 42 Twyford Gardens on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified multiple breaches of regulations at this inspection. Please see the action we have told the provider to take at the end of this 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Detials

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

42 Twyford Gardens

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
This inspection was carried out by one inspector and one assistant inspector.

Service and service type
42 Twyford Gardens 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. 42 Twyford Gardens 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 not a registered manager in post.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 8 September 2022 and ended on 22 September 2022. We visited the location's service on 8 September 2022.

What we did before the inspection
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider, the local authority and other agencies and health and social care professionals. This information helps support our inspections. We

received email feedback from two social care professionals about their recent knowledge about the care being provided at the service.

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 information gathered as part of monitoring activity that took place on 4 August 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and observed two people's experience of the care provided. We spoke with four members of staff, including the interim service manager ('the manager') and the regional manager. We reviewed a range of records. This included two people's care and medication records and a variety of records relating to the management of the service, including policies and procedures. We looked at training data and quality assurance records. We received further feedback from health and social care professionals. We spoke with three relatives of people using 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,

- People with risks to their health and welfare related to their complex support needs, including aspiration (choking), behaviours that may challenge, and constipation were not always assessed, monitored and managed safely. These people's care plans and risks assessments lacked detail or contained inconsistent information about how to manage these risks to their health and well-being safely. This increased the chances people could receive unsafe support.
- Two people's choking risk assessments had been reviewed but did not contain enough detail about how to support people to reduce the risk of harm to their health if they began to choke. One agency and one permanent member of staff we spoke with had not been trained to use equipment available in the service to support people to dislodge food if they choked. These staff told us they were not confident about how to safely support people if they choked, including using the 'de-choker' equipment.
- Staff were not always monitoring people's bowel movements, following agreed actions to reduce constipation risks and did not know to give laxative medicines when people needed them. Not all staff had received training to know how to safely support people who displayed challenging behaviours and were supporting them in inconsistent ways. This was not being monitored effectively by staff or management to check people were being supported consistently and safely. This placed people at potentially serious risk of harm to their health and increased the chance they may have experienced avoidable pain and discomfort or distress.

Using medicines safely, Learning lessons when things go wrong

- Medicines were not safely managed. Staff were not recording administration of medicines accurately or consistently and were not able to evidence all people's medicines had been given as intended. There had been multiple administration errors occurring consistently since May 2022 meaning people had not received medicines as intended due to staff error. This increased the risk of harm to their health and emotional well-being.
- Medicine stock control systems were not operating effectively to allow staff to know how much medicine was being kept in the service, increasing the chance of theft or misuse or people not having enough medicine. There had been several recent incidents where people had missed being given some of their medicines due to stock not being ordered on time and stock running out.
- Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not always effective. Quality checks of medicines management were not effective in preventing medicine errors. Staff we spoke with confirmed there was confusion over whose responsibility checking things like medicines was, which is why it was not done.
- There had been a high number of unexplained bruising incidents reported over the last three months. Staff

and management had not effectively analysed causes of incidents, share learning, agree on-going actions and monitor people's support to prevent these issues consistently re-occurring. One staff said there was no feedback or follow up from managers if they reported incidents.

The provider had failed to assess, monitor and manage risks to people's' health and safety, provide safe care and treatment, manage medicines safely, or ensure lessons were learnt. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●All of these risk management and medicine concerns were fed back to the provider during the inspection who acknowledged the issues.
●After our inspection visit, we asked the provider to send us further information about immediate actions they would take to address issues relating to people's choking and constipation risks. We received these assurances as requested, which included how the provider would make immediate risk management improvements.

Systems and processes to safeguard people from the risk of abuse,
●Systems and processes to keep people safe from abuse and improper treatment were not operating effectively.
●Not all staff had received safeguarding training or updates. Staff we spoke with were not confident or did not know how to report suspected incidents of abuse. Staff were not always aware of the provider's whistleblowing or safeguarding polices.
●A person living at the service we spoke with said they did not know which staff to talk to if they needed to report abuse concerns and were not confident staff would act to help them if they did.
●There had been recent safeguarding incidents involving allegations of abuse against people at the service by staff, raised by visiting professionals. These incidents had not been recognised as potential abuse or reported internally or externally by the provider. This increased the chance that the provider and other partnership agencies would not know and be able review and act on any abuse allegations to keep people safe.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing rotas were not always managed safely. The service currently had several unfilled support and management staff vacancies for which recruitment was on-going. The provider was employing regular long-term agency staff to cover staff vacancies. Permanent and agency staff said they did not always know how to meet people's needs and told us they were not receiving regular training, supervisions or competency checks.
●The provider told us they used a dependency tool to assess staffing ratios, based on information about people's needs and funding. However, People and staff told us they did not think there were always enough staff deployed to be able to meet people's needs safely and effectively. For example, people who required two staff to transfer from one surface to another due to physical disabilities could have to wait for support with personal care due to not enough staff working on each shift. There were not always enough trained staff to administer medicines or take people out for their allocated 1:1 hours. One staff said, "I don't think staffing levels are safe enough and people are missing out".

Preventing and controlling 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 using PPE effectively and safely.

● 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 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 provider was facilitating visits to people living at the home in accordance with current infection prevention and control guidance.

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.

Staff support: induction, training, skills and experience

- The provider had developed comprehensive induction, training and supervision programmes for permanent and agency staff. However, agency and permanent staff told us they had started work without receiving or accessing any of these programmes. This increased the chance staff would not know how, or have support to, enable them to support people to achieve good outcomes.
- One staff member said, "I wasn't supported to learn the job when I started, no training and there was no sit down with a manager or a mentor. I don't feel good about this, I hardly know anything". Other staff and one person we spoke with told us they did not think that all staff had the necessary skills or experience to be able to meet people's needs effectively.
- A relative told us that with the high turnover of staff, new starters and agency staff did not always been trained to be able to effectively meet all of their family members' needs, which had resulted in their relative not having the right support.
- The interim manager confirmed not all staff had received necessary training or induction and explained this was the result of recent high turnover of management and staff.

Failure to ensure staff had received appropriate support, training and personal development to carry out the duties they are employed to perform is a breach of Regulation 18 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,

- People's needs were not always holistically assessed to consider what people wanted and needed from their support. While we did not observe any overt or direct discrimination, staff had not always considered people's social, mental and emotional needs or associated best practice guidance when delivering people's support.
- For example, people using the service whose emotional based behaviours had not been supported to by staff to carry out a functional assessment of their behaviour support needs. Functional assessments help people avoid the need for using reactive and restrictive practices, enhance their quality of life and learn new skills.
- Autistic people did not have assessments that showed staff had considered if and how their support needs related to this condition. This increased the chance people may not be experiencing the best quality of life or being offered support that helped them to achieve good outcomes.

Supporting people to live healthier lives, access healthcare services and support, Staff working with other

agencies to provide consistent, effective, timely care

●Staff told us they spoke with people about their health and observed their day-to-day health needs. We saw examples where staff had supported some people to make referrals to health care professionals quickly where people had become unwell.

●Records were kept of people's healthcare appointments and people had 'care passports' to help share information with health professionals about people's medical needs. However, staff were inconsistent in recording their formal monitoring of people's on-going healthcare needs, such as constipation and fluid intake. The manager and staff told us reviews of people's healthcare support were not always been carried to check people had appropriate support, or to ensure any health information shared with other agencies was accurate.

●Healthcare professionals told us staff had not always worked well with them, which delayed assessment processes and timely delivery of people's care. One professional said, "Staff gave me and then the psychiatrist directly contradictory information on 2 subsequent days, which affected the assessment process…. (There has also been) delayed provision of requested care plans / risk assessments".

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 service was not always working within the principles of the MCA. Staff did not always understand the relevant consent and decision-making requirements of this legislation.

●People's mental capacity to be able to make decisions about different activities had not always been assessed or regularly reviewed by staff. Where people had been provided with support when they were assessed as not being able to make certain decisions, it was not always recorded that the person with authority to act in their best interests had been identified and involved in agreeing this. This increased the risk people may receive unnecessarily restrictive support that was not in their best interests.

●Where renewals of DoLS authorisations were needed, these were in the process of being applied for by the current interim manager.

Failure to ensure people's consent to care and treatment had been sought in accordance with legislation is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff had sought advice from speech and language therapists (SaLT) about people's specific dietary needs and to help develop eating and drinking guidelines, although these did not consider what to do if a person actually began to choke. During our inspection visit, we observed people were given meals prepared according to their personal eating and drinking care plan guidelines.

●One person's fluid intake had not always been consistently recorded, however we observed they were being offered and having drinks regularly during our visit. One person told us they mostly enjoyed the food at the service and could drink whenever they liked. There was an accessible water cooler in their room to

allow them to drink often. Staff told us they had recently started to expand people's menus and encourage them to try new food choices.

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

● The service had a communal kitchen, dining room, lounge and a garden where people could take part in activities and meet with other people and visitors. People could spend time in their individual rooms whenever they wanted, and these had been personalised according to their choices. Each person had their own toilet and shower room.

●There were wide doorways and ramps to the front and back doors to help people move around the home freely. Bedrooms had been equipped with track hoists to help people who needed support to be able to transfer from one surface to another.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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, Supporting people to express their views and be involved in making decisions about their care

●Staff and people we spoke with raised concerns about some staff not treating people with kindness or compassion, which increased the risk of people's emotional well-being and quality of life being impacted negatively. One staff member said, "I would not be happy for my family member to live here, staff are not caring enough".
● People were not always supported in an inclusive or respectful way, offered choices or involved in their care. We observed some staff using disrespectful language to describe one person's emotional distress.
●A person told us they could say what food they wanted but were sometimes given a soft diet although they were not at risk of choking. The person said this was because another person who was at risk of choking needed a soft diet, so it was easier for staff to just make one meal. Other staff confirmed this happened, and that they were trying to talk to the team and stop this happening.
●A person told us they were not always able to be provided with personal care support by staff of the same gender and did not feel this request was being taken seriously.
●Staff and people told us some staff did not listen to people and made choices for them, even when they did not need support to make decisions.
● A person said some staff asked their preferences and involved them in their support, but other staff did not. They said, "I am not physically restricted, but I feel uncomfortable".
●A staff member said some staff were "over-bearing", did not listen or support people's independence and, "tried to run the home like an institutional care home". A person said some staff "make decisions for us".
●A health professional told us they had raised concerns following a visit to the service about lack of caring support for people, regarding staff knowingly let a person wear what they thought were another person's glasses and not their own.

Failure to ensure people were always treated with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Three relatives we spoke with raised no concerns about staff not being caring towards their family member and respecting some of their choices. One relative said "They find one [staff] they like more than the others and they make them the primary carer".
●A person told us staff respected their privacy during personal care tasks and they had time to be alone if

they wanted.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences, 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 did not always have support to plan or receive personalised care. A person told us they were not involved in planning or writing their care plans or risk assessments. They said that not all staff knew their needs well or what support they wanted. Staff we spoke with and then interim manager told us they were not sure what the processes and systems were for planning and delivering personalised care for people at the service. This reduced the amount of choice and control people had over the delivery of their support.

●Some people's care plans lacked detail about their individual preferences, emotional and social needs as well as their strengths and levels of independence. This increased the risk staff may be neglecting or not responding in the best way to people's personal wants and needs.

● People were not being supported to regularly identify, or review, on-going individual aspirations and life goals, affecting their overall quality of life. This included not having support to follow their interests and take part in appropriate social activities. One person said, "I used to have 1:1 hours but lately I have not been getting these due to staffing issues".

● One staff member said, "although there are some barriers with people's financial situation, we need more person-centred activities, no one (staff) wants to make the effort to change, people do the same stuff week after week, same routines". Another staff said, "I don't feel all staff try to help people live a fuller life".

●During our visit we saw that one person sat on the sofa for the entire day and was not offered any activity other than watching television or eating and drinking, although there was two staff available to support them for the majority of the day. Staff told us this was normal for most days for this person. They said, "they never go out, we need to work at encouraging them but there is no plan about how to do this at the moment".

●A relative told us they thought staff were not doing enough to encourage their family member to follow their interests or go out enough, and this was having a negative impact on their quality of life. They told us they were not doing activities they used to enjoy and found stimulating. Another relative told us staff did not support their family member to plan for future goals or achieve any aspirations.

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 (AIS) 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.

●The manager told us the organisation was able to provide accessible information for people who required

this. They said, "Some of the accessible information formats need to be incorporated into this service". We did not see information about people's communication preferences in care records we reviewed, or that staff were using any specific forms of accessible communication tools when supporting people at the service.

The provider was not ensuring people received person-centred care. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

. Improving care quality in response to complaints or concern

●Improvements were needed to ensure complaints were consistently well managed. We received feedback that a person was not confident to make complaints to staff. ●A relative told us, "I don't know the ins and outs of how to make one [formal complaint]. I've not been given information on how to. I always ring the office if I have a problem". They told us they were usually able to speak with staff who listened to any concerns they may have.

●The provider had a complaints policy and staff told us they would report any complaints to the manager for investigation.

End of life care and support

● No one at the service was currently being supported with end of life care. The manager told us there was an internal health and well-being team who could offer support if people needed to consider advance care planning, to make sure they got the right support, resources and equipment to have as dignified and pain free a death as possible.

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.

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

- Internal quality processes to review and audit service performance and quality were not operating effectively. These had not always identified or prevented issues occurring or continuing at the service. This included audits not identifying issues with choking and constipation risks, as identified during this inspection or preventing frequent medicine errors.
- The service had been without a CQC registered manager since April 2022. There had been interim management arrangements since that time, including the appointment of a permanent registered manager who had then subsequently left after a short period.
- Prior to and since the registered manager left, leadership at the service and the provider's governance frameworks had not been effective in ensuring staff at all levels were aware of their responsibilities, relevant legal requirements were met, and a good standard of care was provided. Multiple breaches of regulations had occurred, placing people at avoidable risk of harm to their health and well-being and impacting negatively on their quality of life. Statutory notifications had not always been submitted to CQC in a timely manner, as required.
- A person we spoke with said "We have had a lot of managers this year, I find it unsettling. There is often no manager to talk to, and things are going wrong with my support that shouldn't be like running out of my medicines. I think the service is going through a lot of difficulties".
- Staff members we spoke with said the turnover of managers had meant there was uncertainty and confusion over their own and other staff member's job responsibilities, and they felt nobody was holding either individuals or the staff team accountable for their performance.
- A health professional told us they had raised concerns earlier this year about lack of effective manager coordination of people's care affecting the safety and quality of people's support.
- Two people's relatives told us the management turnover made them concerned about lack of oversight at the home. They both said staff communicating about changes at the service and following up on actions about their family members support was not always consistent.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A person we spoke with told us they did not feel fully engaged and involved in how they were supported, and the service was run. They told us about a negative atmosphere within the staff team that affected their quality of life and meant they did not get good support. They said, "This service is going through a lot of

difficulties. The atmosphere has gone downhill a lot and I want to go out every day to get away from it. Night and day staff do not talk to each other and this means things get missed for me".

●Staff and management at the service had not ensured there was a positive, inclusive, open or empowering culture within the service. Both staff told us they did not feel supported by the provider. One staff said, "Some of the members of staff are quite negative about working here and is quite a toxic environment. Lot of backstabbing, putting people down. People are not getting person-centred care, some members of staff will sit at table for most of the day once personal care has been completed." Another staff member said staff would openly disagree whilst working together and complain a lot. They told us, "This knocks people's confidence and can mean information about people's support needs isn't shared. The previous managers were not professional or approachable, although this is getting better now the last manager has left".

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, Working in partnership with others

●The previous managers had not always shared information appropriately with external agencies and stakeholders when necessary. If the provider had not been aware of when things had gone wrong with people's support at the time, they had taken appropriate action to be open and honest when they had been made aware of this.

●Health and social care professionals told us staff had not always worked well with them in the past, including not sharing information openly and transparently and helping to resolve issues when things had gone wrong.

There were failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, staff worked well with partnership agencies and service performance was evaluated and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●The interim manager had only been overseeing 42 Twyford Gardens for two weeks prior to this inspection and was currently managing another one of the provider's services, where they had been in post for a long period. They said they planned to start implementing new supervision and quality assurance programmes and embed organisational performance management systems to support the staff team to improve and monitor quality and safety more effectively.

●The regional manager gave assurances they were committed to providing resources to make any necessary improvements as quickly as possible, including carrying out more effective and comprehensive audits. Staff told us over the last few weeks the provider had recognised the need for change at this service and were actively promoting the need to create a better working and living environment for staff and people.

●The provider had an Equality and Diversity Policy and the interim manager told us how it was important to them and as leader within the provider's organisation, they always promoted and respected staff equality and diversity. They said, "I make sure that within my staff teams there is always respect for other people's cultures, beliefs, and that everyone receives equal opportunities regardless of race, gender or sexual orientation". They gave an example of how they had supported staff equality and diversity at another of the provider's services they were currently managing.

●The provider had a clear vision and set of values that they expected staff to display when performing their roles, including making things happen and valuing everyone. The interim and regional managers told us they were promoting these values and how they linked to both provider and staff responsibilities via their quality assurance, human and business resource systems as part of the planned service and organisational development plans.

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 was not ensuring people received person-centred care. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Failure to ensure people were always treated with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to ensure people's consent to care and treatment had been sought in accordance with legislation is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 failed to assess, monitor and manage risks to people's' health and safety,

provide safe care and treatment, manage medicines safely, or ensure lessons were learnt. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, staff worked well with partnership agencies and service performance was evaluated and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff had received appropriate support, training and personal development to carry out the duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.