Sense

SENSE Tanglewood

Inspection report

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22 January 2024

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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?	**Inadequate**

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
SENSE Tanglewood is a residential care home providing personal care to up to 7 people. The service provides support to people with sensory impairment, learning disabilities and autistic people. At the time of our inspection there were 6 people using the service. The service is provided in a large, detached home in a residential area.

People's experience of using this service and what we found
Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People did not always have support that matched their assessed needs, and where people were assessed as needing additional support to manage risks, this was not always provided.

Right Care:
Care was not always person-centred and did not always promote people's dignity, privacy and human rights. People were not always engaged in meaningful activities and where people had hobbies and interests this was not reflected in what they did through the day.

Right Culture:
Whilst there had been an improvement in the culture, ethos and values in the service; attitudes and behaviours from staff did not always ensure people using services lead confident, inclusive and empowered lives. The provider's governance systems were not effective. Governance systems did not ensure people were always kept safe and received a high quality of care and support in line with their personal needs.

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
The last rating for this service was inadequate (published 7 September 2023).

At this inspection we found improvements had been made and the provider was no longer in breach of some regulations, however the provider remained in breach of other regulations.

This service has been in Special Measures since 7 September 2023. During this inspection the provider

demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

Enforcement
We have identified breaches in relation to person-centred care, people's safe care and the governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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 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**

SENSE Tanglewood

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of 1 inspector on the first day and 2 inspectors for the subsequent 2 days.

Service and service type
SENSE Tanglewood 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. SENSE Tanglewood 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 not a registered manager in post. A new manager had was in post and had applied to register. CQC are currently assessing this application.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 15 January 2024 and ended on 22 January 2024. We visited the location's service on 15, 17 and 22 January 2024.

What we did before the inspection

We used all this information to plan our inspection.
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with 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 all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and observed how other people were being supported. We spoke with 6 members of staff including senior operational staff, the manager and care staff. We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 4 agency staff profiles and 3 staff files in relation to safe recruitment and a variety of records relating to the management of the service, including policies, procedures, and safeguarding incident records.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant whilst we saw some improvement, 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; Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People did not always have risks to their health and safety effectively managed. One person had epilepsy and staff told us they were experiencing seizures. However, their seizures were not being monitored, this increased the risk of poor clinical treatment as information on the frequency, duration and intensity of seizures was unavailable. Another person had instruction from an epilepsy professional in their care plan stating no lavender-based products to be used due to the potential interaction with seizures, however we found open lavender massage oils in the persons bathroom cabinet.
● One person's care plan instructed staff to ensure no products were left accessible in their bedroom or bathroom. However, we found a bathroom cabinet with no lock containing products that were harmful if swallowed in the person's bathroom cabinet. This cabinet was accessible to the person leaving them at increased risk of harm.
● Where people were assessed as requiring one to one support to manage their risks this was not always provided. For example, we observed one person who was assessed as requiring one to one support at all times. On 22 January 2024 the inspector and a member of management staff observed this person alone in their room and on the floor. We were unable to locate the allocated member of staff. To mitigate this, the manager reallocated an alternative member of staff from supporting another person who was also assessed as requiring one to one support at that time. We observed another member of staff asleep whilst supporting a person in their room. This left people at risk of harm as risk was not being managed in line with their assessed needs. We escalated this to the nominated individual who took action to address these concerns.
● There were systems of oversight that enabled action to be taken where things had gone wrong and improvements in systems to safeguard people and also in the management of medicines. However, there were still improvements to the care and treatment of people that had not been made since the last inspection and the provider remained in breach of regulation.

People's care and treatment was not provided in a safe way and risks to people's safety was not managed effectively. This is a breach of Regulation 12 (Safe care) of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to take action to protect people from abuse and improper treatment. This was a breach of regulation (13) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation.

● The provider had improved the systems to safeguard people from the risk of abuse. At the last inspection action was not taken to investigate concerns or take action to protect people from abuse. At this inspection we could see where staff had recorded concerns. For example, marking where bruises were present on a person, action was taken to investigate and where necessary to make a referral to the local authority safeguarding team.
● Staff told us they felt assured that action was taken when concerns were raised. Staff told us they felt more empowered and confident to raise any concerns.

Staffing and recruitment
● The provider's recruitment process included checks to ensure staff were safe to work with vulnerable adults. Staff files showed recruitment checks were robust, which included checks on staff through the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Whilst we found that there were sufficient staff to meet people's needs and staffing allocations matched what was identified in their care records, we found that staff were not always effectively allocated. For example, 1 person was identified as requiring one-to-one support to manage their needs and to reduce risks to the person if left unsupported. There were times throughout the days of the inspection that this person was alone in their room. When we discussed this with the manager, they told us at times the allocated staff member was carrying out other domestic tasks in the service leaving the person unsupported. We were not satisfied that there was adequate allocation of staff to keep the person safe.
● Current recruitment challenges had meant an increased reliance upon agency staff.
● We checked the agency profiles. This information helps providers be assured that agency staff have had the necessary recruitment checks from their employers. We found some of these profiles were not up to date, however these were for agency staff who had not recently worked in the service. When we raised this the provider took immediate steps to ensure the records for all of the agency staff were up to date.

Using medicines safely
● At our last visit we found medicines were not always managed safely. Medicines had not been stored safely and we found there was a risk of medicines that had exceeded their used by date could be administered. At this inspection we found improvements had been made. There was a robust medicines system and we found effective stock monitoring and rotation. All medicines we checked were within their expiry date.
● Medicines were stored securely and in line with the prescribed instructions.
● People received their medicines from staff who had training and checks on their medicine competency.
●Medicine that needed to be given at a specified time for example before food, were administered in line with the prescribed instructions.

Visiting in care homes

- There were no restrictions to visiting at the time of the inspection.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant that although we observed improvements, 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
At our last inspection the provider had failed to deliver care in a way that was reflective of the Mental Capacity Act 2005, this was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was use of restraint without the correct decision-making processes and authority to use restraint. At this inspection improvements had been made and the provider was no longer in breach of this regulation.

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.

- Systems were now in place to ensure that decisions made regarding people's care and treatment followed legal requirements. Where previous decisions had been made, these had been reviewed in line with best practice and best interests. As a result, the service had adopted the providers own policies, procedures and ethos around least restrictive practice.
- Staff had training around the Mental Capacity Act and were able to tell us about the principles around consent and best interests.
- People were supported to make choices at mealtimes with staff taking time to presenting choices and options. However, providing choice for people on how they wanted to spend their time through the day was limited.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection the provider had failed to ensure safe management of people's nutritional and

hydration needs. Paperwork relating to peoples eating and drinking needs did not reflect best practice or national guidance. There was contradictory information regarding peoples eating and drinking needs. This was a breach of regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation.

● Conflicting information had been removed from food preparation areas. We found that the provider had taken steps to identify and then refer people to speech and language therapy (SaLT) where needed to refresh eating and drinking guidelines.
● We saw that staff prepared food in the way identified in people's care plans and people had access to fluids when they wished.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw evidence that care plans were not always fully up to date which meant agency staff may follow care plans which were no longer appropriate for individuals. It was not clear if staff had read and understood care plans and risk assessments for people. When we looked at the sheets in people's care records that asked staff to sign to indicate they had read a person's care plans and risk assessments these were not completed. When we asked the manager how they were assured staff had understood the latest care plans and risk assessments for people, we were told staff had been given a deadline for completing this.
● Not all care records reflected people's needs. People had comprehensive assessments prior to moving into the service and the provider was in the process of reviewing and updating care plans and risk assessments. However, some of the care records, despite being updated, missed important information regarding risk. For example, 1 person's care records said they were only to have female carers for personal care and staff confirmed this. When we looked at the care records, there was no care plan or risk assessment covering this. We also found male staff had continued to provide personal care. The manager took immediate steps to address this and ensured that care plans were clear, and that male staff were no longer delivering personal care to this person on their own.

Immediately following the inspection, the provider was taking steps to review the processes for updating people's care records.

Staff working with other agencies to provide consistent, effective, timely care, Supporting people to live healthier lives, access healthcare services and support
● People were referred to other agencies where needed, for example psychiatry services and epilepsy services. However, instruction from professionals was not always clearly followed by staff or the management team. For example, the need for clear recording of seizures, which was not being carried and potentially impacted upon the care and treatment of the person's epilepsy.
● The management team were welcoming of the inspection and feedback and continued to engage proactively with us following the inspection.

Staff support: induction, training, skills and experience
● Staff said that new staff had induction training including working alongside more experienced staff and training before they commenced shifts. Staff had access to training appropriate to their roles, this included training around equality, diversity and human rights. The provider had systems to identify when staff needed refresher training and what training staff had completed.
● Staff told us they felt more supported by the management team since the last inspection. The provider was working to establish consistent supervision as this had not yet been established since the change in the management of the service.

Adapting service, design, decoration to meet people's needs
At our last inspection the provider had failed to ensure the premises and environment were safe and secure. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were damaged window restrictors and doors that were not secured which could lead to people leaving the building.
At this inspection improvements had been made and the provider was no longer in breach of this regulation.

● All areas identified regarding the home environment at the last inspection as needing attention had been actioned. Fresh window restrictors had been fitted throughout the service, with fresh locks fitted to doors where needed.
● People's rooms were personalised and the maintenance around the home had improved since last inspection.

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 requires improvement. The rating for this key question has remained 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 saw that during the process of providing personal care staff ensured curtains and doors were closed to ensure people were afforded dignity. However, not all the care and treatment always promote people's dignity or privacy. For example, we observed a staff member using their mobile phone whilst facing away from one person. For the period of the observation the member of staff did not speak or give eye contact to the person

● Where staff were allocated to work with individuals at the start of a shift there was no consideration of the gender or experience of staff providing intimate personal care. Male agency staff were providing personal care to females, even though there were experienced female staff on shift. Staff told us "we used to do gender sensitive care, but we do not do that anymore." When we looked at people's care records there was no information about people's preferences or needs. This did not reflect an approach that considered the most appropriate care and treatment or took account of service users' individual preferences.

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

● Involving people in day-to-day decisions about their care was inconsistent. We saw where some staff would take time to engage and listen to people about what they wanted to do and supported those decisions. We saw other staff not take the time to support people to express their views and decisions about what happened during the day were made for rather than with the person.

● There was no mechanism for capturing people's views on their care, and no reflection in people's care records of their input or involvement in the care they received.

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 requires improvement. At this inspection the rating for this key question has remained 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, Meeting people's communication needs
At our last inspection the provider had failed to ensure care was person-centred. This was a breach of regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection not enough improvement had been made and the provider remained in breach of this regulation.

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.

● Whilst there were assessments of people's communication needs in care records, not all staff or management took time to understand the individual needs of people using the service. For example, staff told us 1 person had recently started to pull their hair out and this was happening with increased frequency. This person was not able to vocalise their needs due to the complexity of their health needs and therefore used other ways to communicate. However, staff had not sought to understand the root cause of this behaviour change; instead referring to this as 'challenging behaviour'. This meant no consideration was given to learning more about this person in order to understand what they were trying to communicate; therefore, not supporting a person centred approach. Following the inspection, the manager took action to identify the causes of the changes in behaviour including contact with the local learning disability team and making a GP referral.
● However, we saw examples where staff took time to utilise alternative methods of communication for people. For example, a staff member used touch on a person's hand to initiate communication. Following this the staff member explained to us that this was a recognised form of communication. The person's care records confirmed this.
● People's experiences did not consistently reflect an approach that promoted people's preferences, aims, wishes, or goals. Activity was sporadic and did not reflect what had been recorded in people's care records regarding their preferences and interests.
● Care was not planned in a way that reflected a person-centred approach. For example, 1 person had a

care plan that included a section entitled 'Important things to (person)'. This contained information on a range of things that they liked to do including maintaining social contact, going for walks, cinema, access to transport and music activities. There was also a 'weekly activity plan' which reflected a range of activities both in the community and in the home. However, there was no evidence in the care records or through our observations that consideration of these 'important things' were given in how the care was planned or delivered.

Care was not provided in a way that was person-centred. This was 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 concerns

- There was a system for triaging and managing complaints and the systems to act on concerns had improved since the last inspection. There were no current complaints at the time of the inspection.

End of life care and support

- There was information in people's care records about end of life wishes.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate.The rating for this key question has remained 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care
At our last inspection the provider there was no effective management or governance of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The service did not make use of effective systems and processes to make sure they assessed and monitored the quality of the care for people in the service. It had failed to identify that people were having poor outcomes from the care that they were receiving on a daily basis.
- Managers directed staff away from tasks essential to keeping people safe without undertaking risks assessments to identify if this was appropriate.
- Managers were not aware of the risks to the service which were identified during our inspection
- The service did not undertake, learn from or share an effective programme of review or audit to ensure staff consistently worked to keep people using the service safe.
- The providers systems and processes to review and update peoples care records had failed to ensure that all risks were accurately reflected and communicated to staff.
- There was no effective mechanism to support and engage people in their care. There were no regular reviews that included the people using the service or meetings to enable people to engage with the management of the service. Whilst the provider is engaging with an external resource to commence person-centred reviews for people, this was yet to commence and there was no evidence of positive impacts for people during this inspection.

There was no effective governance and oversight. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Whilst formal supervision for staff was still to be established, staff told us they felt more supported by the fresh management team, and systems of communication between staff and the manager had improved.

● We found improvements had been made to how safeguarding concerns were managed and we could see that the culture was now open and engaging with external professionals.
● The provider had taken positive steps to improve the oversight and support of the management team in the service.
● The provider acknowledged that further emphasis and work was needed to improve the quality of support and outcomes for the people in the service.

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

At the last inspection there had been a failure by the manager to act in a way that was open and transparent. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection improvements had been made and the provider was no longer in breach of this regulation.

● The provider had taken steps to openly review any concerns or incidents that had not been addressed at the time of the previous inspection. This had involved the local authority and safeguarding where relevant.
● Systems and processes now reflected increased openness and engagement with external professionals.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not provided in a way that was person-centred.

The enforcement action we took:

We have served a notice of proposal to impose positive conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and risks to people's safety was not managed effectively

The enforcement action we took:

We have served a notice of proposal to impose positive conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no effective governance and oversight.

The enforcement action we took:

We have served a notice of proposal to impose positive conditions on the provider's registration