Cygnet Care Services Limited

Oakhurst Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**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
Oakhurst Lodge is a care home, without nursing, that provides care and support for up to 8 adults with autism and learning disabilities and other multiple needs. The home is on the outskirts of the New Forest in a community setting between Southampton and Lyndhurst.

At the time of the inspection there were 7 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

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

Right Support
More needed to be done to ensure people were consistently supported to have a fulfilling and meaningful everyday life that included achieving aspirations and goals and having regular access to meaningful activities. Whilst the service had planned for when people experienced periods of distress, the plans lacked completeness and in some cases contained inaccuracies. This increased the risk of inconsistent approaches being used which could increase people's distress. Staff were not consistently supporting people to make decisions following best practice. Staff enabled people to access health care services in their local community and care was provided in a clean and generally well maintained environment.

Right Care
Managers had not always ensured risks faced by people had been assessed and planned for. The risks posed to people due to the complex needs of their peers had not been adequately assessed and planned for. Concerns were raised that leaders had not always responded appropriately to concerns about abuse. More needed to be done to ensure staff understood people's individual ways of communicating. There were usually sufficient staff deployed to meet people's needs within the home, but hours aimed at supporting community activities were not being fully utilised.

Right culture
There were a range of governance processes in place, but these were not being fully effective, as the inspection found a number of areas where the safety and quality of care being provided had fallen below the required standards. The culture within the service was kind and caring and staff in all roles were passionate about their work. Staff were recruited safely.

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

Rating at last inspection
This last rating for this service was good 27 February 2018.

Why we inspected
We undertook this inspection to assess whether the service was applying the principles of Right support right care right culture.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns about record keeping, the management of incidents and potential restrictive practices being used. A decision was made for us to inspect and examine those risks.

We have found evidence the provider needs to make improvements. Please see the safe, effective 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement
We have identified breaches in relation to safe care and treatment, consent, person centred care, safeguarding people from abuse and good governance.

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Oakhurst Lodge

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
Two inspectors and an assistant inspector carried out visits to the service. A member of the CQC medicines team provided remote support and an Expert by Experience made calls to people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oakhurst Lodge 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since it was last inspected. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We used Talking Mats a symbol based communication tool to seek the views of 1 person about their experiences of living at Oakhurst Lodge. We also focused on completing observations throughout the day and into the evening. We spoke with the registered manager and deputy manager, a team leader and 4 support workers. We also spoke with the operations director, regional manager, chef and regional maintenance manager. We reviewed a range of records. This included 4 people's care records and medicines records and 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed. Our expert by experience spoke with 5 people's relatives and the inspector spoke with 1 further relative.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from 3 professionals who visited the service. We received written feedback from 4 more staff.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

- Whilst there was evidence of some good practice, and of some person centred approaches being used, our observations, a review of records and support plans, and discussions with staff identified people were not consistently being supported in accordance with current best practice guidance when they experienced periods of distress.
- Lengthy positive behaviour support plans were in place but despite this, some of those viewed lacked clear guidance and completeness or used inaccessible language and were not fully understood by staff or the leadership team.
- There was a lack of information about how some of the proactive approaches described were to be used. In practice this left staff having to interpret guidance around strategies, structure and boundaries.
- One person was new to the service. There had been a lack of collaboration with the MDT, during the person's transition to the service, regarding their need for a PBS plan and so this was not yet in place.
- Incidents and accidents had not always been managed well.
- Some incident records were not fully completed or contained conflicting information.
- Where safety interventions or restraint had been used, it was not always documented which staff had been involved in the incident or how long the restraint had been used for in keeping with the providers policies and best practice.
- A number of incident forms referred to people being supported to their room or another area during heightened states of anxiety. There was no detail stating how this support had been provided.
- Records did not support that the potential cause of any injuries or bruising that occurred during the use of restraint had always been fully explored.
- On 2 occasions, staff had been involved in supporting people with advanced safety interventions without having the correct level of training. This put people and staff at an increased risk of harm. The provider's processes and systems had not been effective in identifying or prevent this risk. The provider is taking action to ensure all staff have this training as a priority.
- It was the provider's policy that people should be carefully monitored, and checks recorded following the use of advanced safety interventions such as a supine restraints. There were no records available to provide assurances this had happened following the use of a supine restraint on 17 May 2023.
- Whilst post incident debriefs with staff had mostly taken place, these, overall, lacked detail and there needed to be a greater focus on how approaches could be changed to avoid the need for restrictive interventions in similar circumstances.
- There was a lack of evidence of a detailed review of the circumstances of incidents involving restraint by the leadership team or by the provider and this was a missed opportunity to identify the above concerns,

but also to clearly identify patterns, or triggers, to mitigate the risk of further incidents and to be assured that least restrictive approaches were always being considered.
● Staff were not adequately managing all of the risks associated with the environment.
● A store cupboard used for storing cleaning products had been left open and unattended and therefore presented a risk to people.
● The cleaning products were stored in a cupboard which was locked with a particular type of security key that also opened a number of other rooms and cupboards within the service. Records showed staff had, on at least 1 occasion, given 1 of these keys to a person using the service. We were not assured the risks of this had been appropriately assessed and we were concerned this increased the risk of people accessing potentially harmful items and substances. The provider is taking action to change the type of lock on the cupboard containing cleaning products as a matter of urgency.
● There was no fire protection or fire extinguishers in the external sensory cabin. A smoke alarm has now been installed.
● Little used water outlets were being consistently being flushed. However, for a period of approximately a year, the temperature of the hot water at the sentinel taps was below recommended limits. Testing the water temperature at sentinel taps is important as it helps to identify whether the system is adequately managed against the risk of legionella. These checks are important to manage risks associated with legionella. Discussions with the maintenance manager identified this was due to an error in how / where the temperature was being taken. However, this had not been picked up for by the registered managers or providers checks and addressed promptly.
● Information about risks to people's health and wellbeing was not always comprehensive or up to date.
● The measures in place to monitor 3 people who experienced seizures were not sufficiently robust and did not fully mitigate the known risks, particularly during the night. A bathing risk assessment for a person with epilepsy lacked clarity about where staff should be positioned whilst the person bathed. Another person's epilepsy risk assessment stated they were to have 30 - 60 minute checks. Records indicated this was, in practice, happening every 2 hours. The provider has arranged for a nurse to review the risk assessments and consider whether alarms or other technology might support staff in monitoring this need.
● One person was at risk of choking; their risk assessment gave conflicting information about the level of risk. The choking risk assessment for another person did not include up to date information about the number and dates of choking incidents they had experienced. This is important to help identify trends patterns that might need further action to be taken.
● A rescue medicine was prescribed and available at the service for a person. However, when the person left the service, this medicine had not always been going with them.

Incidents affecting people's safety were not consistently being managed safely. Risk relating to the health safety and welfare of people were not effectively managed or monitored. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

● Whilst we observed people were able to freely access the kitchen, with support, to make drinks or to choose their meal, all of the relatives we spoke with were of the view the kitchen was kept locked at all times with comments including, "The kitchen is out of bounds which I think is a shame as she has in the past enjoyed cooking" and "The kitchen is kept locked even when staff are inside, if I knock, they will always open the door". This led us to be concerned that approaches aimed at promoting people's freedom of movement were not yet consistently embedded within the service.

Systems and processes to safeguard people from the risk of abuse
● Whilst people largely seemed to be at ease and relaxed with one another, 3 staff raised concerns with us that due to the current mix of people living at the service, some people were experiencing periods of verbal

and sometimes physical abuse from a peer who was living with complex needs. Not all of these incidents had been escalated to either the local authority or to the Care Quality Commission.
● We received mixed feedback about how confident staff felt when responding to these distressed behaviours. Some staff felt confident, others expressed concerns of feeling 'overwhelmed' and felt that the advanced safety intervention training had come too late.
● Whilst there was evidence that a recent concern about abuse had been appropriately escalated to other agencies and investigated by the registered manager, concerns were raised with the inspection team by 3 staff that safeguarding concerns were not always taken seriously or escalated appropriately by the registered manager.
● One person had a risk assessment regarding making false allegations against staff. The risk assessment had been written in a manner that guided staff to start with the premise that allegations would be false rather than stressing the importance of reporting these so they could be fully investigated.
● An incident form dated 18 March 2023 recorded that a person had alleged that a staff member had 'hurt them'. There is no evidence that this allegation was investigated. An incident debrief undertaken with this person on 18 April 2023 also alleged that a staff member had been physically abusive toward them. There is no evidence this was investigated or escalated to relevant organisations.
● During a debrief that had been undertaken with a person following an incident in April 2023, the person had alleged that a staff member had been physically abusive toward them. This concern had not been investigated or escalated to relevant organisations.
● The provider has taken action to ensure both these concerns have now been reported appropriately.
● During the inspection, 4 other safeguarding concerns were raised with us. We have reported these to the local authority and the provider is undertaking an investigation. We will monitor the outcome of the investigations to ensure, along with partner agencies, that systems are in place to ensure people's safety.

Systems and processes were not consistently being operated effectively to prevent abuse and to investigate immediately any allegation of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment

● Overall relatives were confident their family member was safe. Comments included, "I feel [relative] is absolutely safe there, if I didn't, I would be fighting for them to move" and "We feel our [Relative] is safe there…we would know if they unsafe by their behaviour".
● However, some relatives also expressed concerns about the complex needs of others living within the service which they felt did at times impact on the safety of their family member.
● We have discussed this feedback with the provider who is continuing to proactively work with commissioners to ensure it carefully reviews the mix of people using the service. In the interim, staffing levels have been increased and the provider's multi-disciplinary team are continuing to undertake monthly reviews and advanced safety intervention training continues to be rolled out as a priority.
● Easy read information was available to enable people to understand how to keep themselves safe and how to raise concerns.
● To promote a culture of staff feeling comfortable to raise concerns, the service had a staff member who was a 'Freedom to Speak up Guardian'. We spoke with the 'Guardian' who told us, "It is positive, it feels like a positive thing". They told us that where possible, concerns raised through this channel were acted on, saying in relation to 1 particular issue, "They listened to us, they actioned it and its all good now".

Staffing and recruitment
● We reviewed the recruitment files of 3 staff. Whilst most of the required checks had been completed, we found there was an incomplete employment history for 1 staff member. The required information was

obtained during the inspection.
● The number of staff deployed was based upon the amount of 1 to 1, 2 to 1 and shared care hours each person had been assessed as needing by their commissioners. Each of the people living at the service had between 12 and 24 hours 1 to 1 hours each day and a certain amount of 2:1 hours to support provision of activities within the community.
● During the week of our inspection, a new person had come to stay at the home. Staffing levels were reviewed and increased in response to the increased occupancy.
● However, the skills of staff was not always being matched to the needs of people using the service. For example, there were night shifts when there were insufficient numbers of staff trained in advanced safety interventions. The provider has assured us all staff will be trained in this area by the 13 June 2023.
● Staff gave mixed feedback about staffing levels. Most staff felt the number of staff deployed was adequate. Some expressed a concern that the numbers were adequate until an incident occurred which could require 4 staff to be involved. They told us it was then hard to provide the 1 to 1 support needed by others.
● Whilst there was evidence people were enjoying leisure activities including walks, drives to the beach and swimming, overall records did not give assurances staff were fully utilising people's 2:1 hours to support access to the community and this was an area where improvements were needed.
● Relatives also raised concerns about this. Comments included, "There are enough staff on during the day… but not enough staff for 2:1 trips" and "Staffing for the 1:1 at the home is good but there are not enough staff who drive for trips out, so it only tends to be trips to the pub or a walk to the [Local Shop]."
● Staff confirmed this could at times be challenging. For example, 1 staff member said, "We can't facilitate trips out in the evening, [Peoples names] would like to do things in the evening, but staff had had to stay on in their time".
● The provider's multidisciplinary team (MDT) had recently been depleted as there had not been an assistant psychologist (AP) in post since January 2023. This role had recently been recruited to and it was anticipated that moving forward there would be greater opportunities for the MDT to use improved documentation to work alongside staff, role modelling approaches and techniques to support consistency.
● Recruitment had been a focus for the provider, and they had undertaken a successful recruitment of overseas staff via the Home-Office sponsorship schemes and agency staff had not been required at the service for some months. This had helped to improve the continuity of care provided.
● In light of our feedback, the provider has increased staffing levels to ensure safety but also to support increased engagement.

Using medicines safely
● Whilst our checks indicated people had received their medicines as planned, some medicines related records had not been updated in a timely manner to reflect changes in the prescriber's instructions.
● Staff had ensured people received information about medicines in a way they could understand. This included the use of easy read documentation.
● Protocols for the use of 'when required' or 'PRN' medicines were in place, but there was scope to make these more detailed by, for example, providing information to support staff with the appropriate use of variable dose medicines.
● Medicines were stored securely.
● The service had ensured people's emotional distress was not controlled by excessive and inappropriate use of medicines. This was confirmed by relatives. Their comments included, "They are very good at only giving [calming or sedative medicines] if absolutely necessary after trying everything else before".

Preventing and controlling infection
● Overall, the home appeared visually clean and there were no mal odours. Relatives largely agreed the home was kept clean but in the absence of a cleaner, some felt this was an area which could, at times, be

improved.
● Cleaning schedules were in place and those seen had been fully completed although opening and closing checks, which help to ensure food hygiene requirements are maintained were not taking place at the weekends when the cook was not on duty.
● 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 were effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Relatives were able to visit people at the service as per the government guidance. One relative told us, "If we ring up it is always ok for us to visit, they are flexible".

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

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 did not consistently demonstrate best practice around assessing mental capacity and best interests' decision making.
- There was a lack of evidence that inclusive best interests' decisions had always been undertaken when mental capacity assessments had determined the person lacked capacity to make a specific decision.
- For example, 1 person who had been living at the service for a year had 3 mental capacity assessments in relation to finances, personal care and medicines support. All had reached the judgement that the person lacked capacity to make these decisions, but none had been followed with an inclusive consultation to agree what support was to be provided in the persons best interests.
- For another person, the best interest's consultation was an email to their relative asking whether they agreed the person lacked capacity to make decisions in a range of areas. It did not outline what the proposed best interests' decisions were so that these could be reflected on as part of the consultation.
- One mental capacity assessment had been carried out the day following a best interest's consultation had been documented for a specific decision.
- Some decisions, such as food and drink preferences, were listed on documents as 'parental choice'. It was not clear the parents concerned were legally authorised to make such decisions and there was no mental capacity assessment, and no best interests' consultation had taken place, to ensure people's rights were upheld during this decision making process.

● The registered manager had made applications for a Deprivation of Liberty Safeguards authorisation (DoLS) where needed, although we identified that DoLS had not always been reapplied for in a timely way and this was an area for improvement.

Legal frameworks regarding consent were not consistently being followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The need for consent

● Staff empowered people to make their own decisions about their day to day care and support and we observed this happening in practice during the inspection.
● The provider was planning on introducing CCTV in the communal areas of the home. Information about this had been shared with people in an accessible format, and with relatives and professionals. Plans were in place to undertake mental capacity assessments and best interests' consultations in relation to this.

Staff support: induction, training, skills and experience
● Whilst the provider had tools in place to ensure staff received a supportive and informative induction, records did not provide assurances these were being used in practice. We looked at the records for 3 staff. One was partially completed and the records for the other 2 staff could not be found.
● Whilst all staff were trained in a safety intervention programme, a more advanced level of training was needed when supporting 1 person. Not all staff had as yet been trained in this meaning that on particular shifts, there would not have been sufficient numbers of trained staff to support with safety interventions should this have been needed.
● Two people had eating and drinking guidelines in place which stated face to face dysphagia training must be completed by staff who supported those people at mealtimes. Records showed only 12 out of 27 staff had completed this training and in 7 of those cases the training had expired. A concern was raised with the inspector that staff not appropriately trained were regularly supporting 2 people who had eating and drinking guidelines in place and shift planners for May 2023 would support this.
● Makaton was 1 person's preferred communication technique; therefore, the provider told us it was a requirement all staff in the service complete level 1 Makaton, however, only 3 staff had completed this so far. The provider told us advanced training had been undertaken by the speech and language therapist, who would develop additional tools for staff to use.
● Feedback from staff indicated, however, that these bespoke, in house, training sessions were not always well attended. This included sessions in behaviour support, understanding of complex conditions associated with autism and calming sensory approaches. This was a missed opportunity for staff to be trained in these areas that might enhance people's care.

People's care was being provided by staff who did not consistently have the necessary skills to meet the needs of the people they were supporting. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

● Other training was in place and included courses covering a wide range of learning such as the Mental Capacity Act 2005, Choking awareness, understanding the provider's values, emergency first aid and epilepsy awareness.
● Staff were also trained in learning disability and autism, positive behaviour support, undertaking post incident reviews, promoting human rights, safeguarding people from abuse and support and engagement. Completion rates of this training were generally good.
● Staff received support in the form of continual supervision, although staff gave mixed feedback about the effectiveness of these.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Our observations, a review of records and support plans, and discussions with staff identified people were not always being supported consistently when they experienced periods of distress. We have reported on this in more detail in the Safe key question.
● The providers multidisciplinary team (MDT) had recently been depleted as there had not been an assistant psychologist (AP) in post since January 2023. This role had recently been recruited to and it was anticipated that moving forward there would be greater opportunities for the MDT to use improved documentation to work alongside staff, role modelling approaches and techniques to support consistency.
● The MDT also worked alongside people to determine their preferred communication method and then drafted guidance for staff on how to meet these needs in practice.
● Communication tools such as now and next boards were being used and 1 person had a place mat with signs and symbols on to support safe eating.
● We noted some areas for improvement. Information needed to be displayed in larger formats / font. Activity schedules were displayed but only had people's initials on. The activities lead acknowledged people would not know which schedule was theirs allowing them to refer to it throughout the day.
● The speech and language therapist had recently completed an inclusive communication audit which was detailed and had highlighted a number of areas where the use of communication tools and the provision of accessible information needed to improve, and an action plan was in place to address this.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet, and food was prepared in line with their cultural preferences.
● The service employed a chef who prepared the meals Monday to Friday.
● There was a suitable dining room where people were supported to eat with support as required.
● Mealtimes were flexible, and the food looked appetising and portion sizes were good. Staff were working with a healthcare professional who was delivering training sessions for both people and staff on healthy eating.
● Overall, the mealtime experiences appeared to be positive for people.
● Staff told us people were being supported to be involved in food shopping, choosing their meals, preparing hot drinks and at weekends in cooking meals. Records partly supported this, but there was scope to further develop the systems in place to support choice and for records to more clearly evidence how independence with meal preparation was being promoted.

Adapting service, design, decoration to meet people's needs
● Overall, the design and layout of the premises met people's needs and the building design fitted into the local residential area.
● On the first day of our inspection the communal lounge felt unwelcoming and lacked any personal touches. The registered manager acted on our feedback and by the second day of our inspection, changes had been made to make the area more homely.
● People had personalised their rooms and there was some evidence people had been involved in decisions relating to the interior design of the home.
● People were able to move freely around the environment and could choose where to spend their time.
● The home had a pleasant outdoor space with paving, swings and lawned areas. The area seemed well used by people.
● Autistic people experience the world very differently to others and so consideration needs to be given to developing an autistic friendly environment based on people's individual sensory needs. To support this a sensory cabin had been built in the garden which was well used as a space to relax.
● Further improvements continued to be planned and senior leadership were holding weekly meetings with

those responsible for managing the premises to expediate any developments needed.

Supporting people to live healthier lives, access healthcare services and support

● People were provided with joined up support which enabled their healthcare needs to be met. For example, staff had developed an effective working relationship with the GP. This had facilitated vaccinations being administered and well person screening services being accessed by people who had previously been anxious about receiving these.

● A healthcare professional told us staff recognises changes in people's health or wellbeing and sought and acted on medical advice in a timely way.

● People were referred to healthcare services such as continence and chiropody services. This was confirmed by a healthcare professional who told us, "The staff are very proactive in ensuring the clients have access to all health services.

● Relatives were confident their family members healthcare needs were met including dental care.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to require 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

- There were a range of governance processes in place, but we were not assured these were being fully effective, as the inspection found a number of areas where the safety and quality of care being provided had fallen below the required standards.
- The provider needed to scrutinise the safety and quality of care being provided to ensure that people were being kept safe and leadership supported to ensure that legislative and regulatory requirements were met.
- There were systems in place to support organisational learning in relation to safety related incidents, the use of restraint and safety interventions and to review and reduce any restrictive practices, but the effectiveness of these systems was limited as the reviews of incident and accidents was not consistently robust as often concluded there were no areas for development or improvement despite the fact many of these records contained omissions or lacked detail.
- Concerns were raised about the consistency with which the registered manager responded to concerns raised by staff about people's safety.
- The culture of the service did not fully reflect the principles and values of Right support, Right care, Right culture guidance and the registered manager was not well informed about this statutory guidance.
- Throughout this report there is reference to concerns regarding the completeness, and in some cases the accuracy of records relating to people's care which had not been addressed through the provider's governance and audit processes.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The registered manager and provider were open and receptive to feedback during our inspection. The provider has developed a robust action plan in response to the concerns raised. This has included increased staffing and managerial support available to the service.
- The registered manager had a good understanding of people's needs and interacted with people in a relaxed and skilled manner.
- Staff told us the registered manager was generally approachable and supportive and it was clear they were invested in the service, had taken steps to reduce restrictive practices and had worked hard to recruit a stable staff team.
- Relatives also felt the registered manager was approachable and generally communicated well, but at

times did not always give them confidence issues were understood and being acted upon. Comments included, "The manager is approachable, perhaps communication could be a bit better on the small things" and "We know the manager very well. He is very laid back which is both positive and negative. He is not fazed by events but then sometimes I don't feel he grabs hold of issues."

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

● People were supported by staff to achieve independence by, for example, being supported to make their own breakfast and complete elements of their personal care and domestic chores. However, overall, records did not provide assurances people were receiving consistent, personalised, and proactive support to reach their goals and aspirations. For example, 1 person's goal support plan stated they should participate in exercise daily / use treadmill. Records did not indicate this was also happening or being consistently encouraged. Another person had a goal relating to being more involved in decisions about which offsite trips they undertook. It was not evident how this goal was being facilitated.

● Whilst there was some evidence of people being supported to participate in their chosen social and leisure activities, this was not happening on a regular basis and records showed the 2:1 hours which facilitated people accessing the community and taking part in hobbies and interests were not being fully utilised.

● 'Pacing around the home' was frequently described as an activity for 1 person and daily notes often referred to others as watching DVDs or being on their iPad or lap top watching video sharing websites.

● Relatives raised concerns regarding the lack of meaningful activities. Comments included, "I don't feel there are enough activities… a typical week will see only 1 activity away from the home other than possibly a walk to the station to look at the trains" and "I am not sure what they do in their room all day".

The care and treatment did not always reflect people's needs and preferences. This contributed to a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The culture within the service was a kind and caring one and staff in all roles spoke passionately about their role with many working long hours or coming in on their days off to catch up on tasks or to support community activities.

● Relatives were confident staff were kind and caring. Comments included, "I have only ever come across staff who are kind", "The staff are very friendly and kind, not only to [relative] but to us as well" and "The regular staff are exceptionally kind and caring".

● We used talking mats to seek 1 person's views about their care and support. They responded positively to the all the areas explored which included the food, the other people they lived with, their room, the garden, trips out, the lounge, noise, medicines, staff and shopping.

● We saw a number of positive interactions. For example, we observed staff using active support to communicate with 1 person in a structured but fun way and this was clearly a positive interaction for the person.

● A healthcare professional who had regular contact with the service told us, "I'd very much like to say that I feel it is a well-run home, [Registered manager] and his team show a huge amount of compassion & kindness to all residents… and whenever I visit, I feel in awe of how amazing they are with each of the residents".

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

● There was some evidence of people being encouraged to be involved in the development of the service, although there was scope to develop this further.

● Information was usually provided in a format people could understand.
● Staff supported people with maintaining family relationships and most relatives felt communication with the service was satisfactory and staff generally kept them informed about their family members wellbeing.
● Staff meetings took place again and minutes showed these were a forum where staff could raise concerns or make suggestions.
● Surveys were being used to seek the views of people and their family members about the quality of the care and provided, however, the action plans developed in response needed to be more detailed in order to clearly identify how these were to be effective at driving improvements.
● Staff had also recently completed a feedback survey. An action plan was yet to be developed in response, but positive feedback had been given about the culture within the service and about the role of the provider's 'Speak Up Guardian'. Areas identified for improvement were communication and access to professional development.

Continuous learning and improving care; 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
● When things went wrong, the provider apologised and gave people honest information and suitable support. This was evident in an investigation that had taken place following a recent safety related incident which had occurred at the service.
● There was some evidence learning from incidents and accidents was shared with staff, although this needed to be more consistent and the quality of debriefs following the safety interventions needed to improve to ensure these were a useful tool for reflecting on practice and to consider improvements in care.

Working in partnership with others
● There was evidence of partnership working.
● Staff worked with independent advocate to ensure people's views were being presented and their involvement in decision making facilitated.
● The leadership team had fostered effective working relationships with external health care professionals, 1 of whom praise the extensive knowledge the registered manager had of people using the service.

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 care and treatment had not always been designed to meet people's needs. This contributed to 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 11 HSCA RA Regulations 2014 Need for consent Legal frameworks regarding consent were not consistently being followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The need for consent

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 Systems and processes were not consistently being operated effectively to prevent abuse and to investigate immediately any allegation of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems in place were not been effective at assessing and monitoring the quality of the service. This was a breach of Regulation 17 (Good Governance) 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 18 HSCA RA Regulations 2014 Staffing People's care was being provided by staff who did not consistently have the necessary skills to meet the needs of the people they were supporting. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to assess and mitigate risks and to operate an effective incident reporting system that helped to protect people from harm.

The enforcement action we took:

We issued a warning notice on the registered manager and registered provider requiring them to become compliant with Regulation 12, section (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 31 August 2023.