Flarepath Limited

Cranmore

Inspection report

Church Road
New Romney
Kent
TN28 8EY

Tel: 01797367274
Website: www.flarepath-care.co.uk

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Cranmore is a residential care home providing personal care to five people with learning disabilities, autism and complex needs at the time of the inspection. The service can support up to six people in one building.

People's experience of using this service and what we found
People continued to be at risk from abuse from one another. Some people could display behaviours that could be challenging to staff and people they lived with. Staff continued to lack the guidance and skill to support people in a positive way. Incidents between people were not always documented or reported to the local authority safeguarding team or the Care Quality Commission.

When incidents between people occurred, there was a lack of guidance for staff to support them to de-escalate situations. Staff accepted incidents of physical abuse between people as normal. Similar incidents of physical and verbal abuse occurred, and staff, the registered manager and the provider failed to put measures into place to prevent these.

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.

This was a targeted inspection that considered risk management and safeguarding under our key question of Safe. Based on our inspection of this area, the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
Right support:
• The model of care and setting did not maximise people's choice, control and independence.
Right care:
• Care was not person-centred and did not promote people's dignity, privacy and human rights
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using the service led confident, inclusive and empowered lives.

Staff lacked understanding on how to support people with autism and learning disabilities. This had a negative impact on people and led to a culture within the service which did not uphold people's human rights.

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 17 June 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider continued to be in breach of regulations. Therefore, this service remained in Special Measures.

Why we inspected
We undertook this targeted inspection to check on a specific concern we had about risks to people and incident management. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to abuse and risks to people at this inspection.

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
Following this inspection, we worked closely with commissioning authorities to ensure people were safeguarded from on-going harm. Five people were supported to move out of Cranmore. There is currently no one living at Cranmore.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about

Cranmore

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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Cranmore 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before 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 did not ask the provider to complete a 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 spoke with three people who used the service about their experience of the care provided. We spoke with six members of staff including two deputy managers the provider and care staff.

and two care workers.

We reviewed a range of records. This included three people's care records and multiple incident reports.

After the inspection
We reviewed incident records and spoke with the director and service commissioners about our concerns.

Inspected but not rated

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check a specific concern we had about incidents between people. We will assess all of the key question at the next comprehensive inspection of the service.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed 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) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse. During the inspection we observed three incidents where people hit or attempted to kick other people. When these incidents occurred, staff made no attempt to re-direct people and therefore similar instances re-occurred. Staff accepted the incidents as normal and did not check on people following incidents to see if they were ok. Guidance on how to support people during times of distress lacked detail and was not reviewed or updated following incidents.
- People told us, and we observed they were distressed by others they lived with. One person told us of another person they lived with, "They poke me in the side and they're so spiteful. Yes it hurts, it does. The staff tell me it doesn't hurt but it does. It's spiteful. Staff just don't do anything. I tell them all the time and they (person) still does it, it drives me mad its horrible."
- Some people had been subject to verbal abuse from neighbours who lived at the providers other adjoining service. There had been no measures put in place to prevent this re-occurring and people from the adjoining service freely accessed Cranmore. This placed people living at Cranmore at continued risk of verbal abuse from the people living at the providers other service next door.
- At our last inspection we identified incidents of abuse were not reported to the local authority safeguarding team or notified to the CQC. At this inspection we found this had not improved. We identified multiple incidents that had not been reported. Incidents of abuse should be reported to the local authority safeguarding team and the CQC so we can check appropriate action has been taken to safeguard people. This helps to ensure the right action is taken to keep people safe. Following the inspection, we reported incidents to the local authority safeguarding team.

The provider had failed to protect people from abuse and improper treatment. This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 (Safe Care and Treatment) 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

Assessing risk, safety monitoring and management

● People were at risk of significant harm from one another and incidents between people re-occurred. One person was pushed over and hit their head. Five days later, another incident, with the same triggers occurred and the person hit their head again. No medical attention was sought for the person.

● Risks to people had not been assessed and measures put in place to support staff. Since our last inspection positive behaviour management plans had been reviewed but still did not contain information to advise staff how to support people during times of distress. Staff continued to not have specific training in de-escalation or how to support people with learning disabilities or autism.

● Other incidents between people had been documented, but no action taken to reduce the risk to people. For example, one person sustained a cut from cutlery being thrown at them. On other occasions people were hit or kicked by others they lived with. No actions had been taken to reduce the risk of harm to people.

● At our last inspection we identified risks with the environment. At this inspection this remained. Since our last inspection some tidying of the garden had been completed, however, there were still objects of concern such as large stones accessible to people. One window at Cranmore had been broken by a person who lived at the providers adjoining service. No attempt had been made to stop people from the providers other location accessing the garden at Cranmore. People at Cranmore remained at risk as a result of the behaviours displayed by people from the providers adjoining home.

The provider had failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider had failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks.

The enforcement action we took:

Urgent cancellation of providers registration

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 had failed to protect people from abuse and improper treatment.

The enforcement action we took:

Urgent cancellation of providers registration