Achieve Together Limited

1 Charmandean Road

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
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
1 Charmandean Road is a residential care home providing personal care to eight people with learning disabilities and/or a variety of associated health and support needs. People live in one large house. There were eight people living in the care home at the time of inspection.

People's experience of using this service and what we found
Right Support
The service did not always support people to have the maximum possible choice, control and independence over their own lives. Staff shortages had impacted on the ability of people to access activities of their choice. One person told us, "I like to go out a lot, but they are always short staffed". Records confirmed people did not always receive support from staff to pursue their interests due to availability of staff. One staff member told us how peoples records were not always accurately detailing the opportunities people had, "Activities don't happen as much as they are written on planner."
The service didn't always record incidents, these included when people experienced distress. Staff and managers failed to learn from incidents and how they might be avoided or reduced. Staff told us of a number of incidents of self- injurious behaviours which had not been managed within a robust incident management process. The service failed to work with people to plan for when they experienced periods of distress.

The service design did not always promote strategies to enhance people's independence. The kitchen could only accommodate one person with staff support at a time due to the size of the room. The kitchen had not been adapted for people who used wheelchairs. The building had limited shared space on the ground floor, mostly people appeared to stay in the dining room. There was a lounge on the first floor, accessible via a lift, our inspection took place over three days and we did not observe people using this room. One relative told us, "[Person] is fed up with going upstairs due to constant noise". People had a choice about their living environment and were able to personalise their rooms.

Right Care
Staff failed to protect and respect people's privacy and dignity. One person was in a state of undress in shared areas of the home for the majority of our inspection, this included the hallway by the front door. Staff had not considered how to protect this person's modesty prior to opening the door to visitors. The provider had not ensured staff had effective guidance to support this person which resulted in staff failing to take any action. We sought urgent assurances from the provider about actions they were taking to mitigate the risks

to the person and minimise the impact of this on others. People and those close to them expressed concerns with how managers and staff had not protected the person's dignity and reported this had been a concern for some years. The impact of this for others had not been considered and had impacted on their ability to live freely in their home. One example included some people being unable to be in their own room for private conversations when they chose.

People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), pictures and symbols could not always interact comfortably with staff and others involved in their treatment/care and support because not all staff had the necessary skills to understand them. One person told us they felt isolated and expressed concerns about their wellbeing. They provided assurances they were able to speak to relatives and staff about this.

Right culture
People failed to receive good quality care, support and treatment because staff could not always meet their needs and wishes. Staffing levels were reported to be consistently below the number required to meet people's needs and to keep people safe. The registered manager and provider had not established, or implemented, appropriate staffing levels that either ensured people were safe, or that they received the care they needed. The providers monitoring and oversight processes was not effective and had not identified the substantial shortfalls being identified Some relatives and staff expressed concern about how issues or complaints would be managed, and this failed to minimise the risks of a closed culture developing. This impacted on the services ability to provide support based on transparency, respect and inclusivity.

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

The last rating for the service under the previous provider was good, published on 14 October 2017.

Why we inspected
We undertook this inspection to assess that the service is 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 that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Following the inspection the provider has taken some actions to mitigate the risks. This is an ongoing process.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment,

safeguarding, staffing and governance at this inspection.

We issued a Warning Notice The provider failed to ensure people were treated with dignity and respect. Staff failed to ensure people's privacy was maintained. The provider is required to be compliant by 14 March 2022.
We served a Notice of Decision on the registered provider. They are required to supply monthly submissions to CQC in relation to compliance with person-centred care, safe care and treatment, safeguarding, staffing and governance.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

1 Charmandean Road

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 Expert by Experience carried out the inspection. 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
1 Charmandean Road 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 registration with CQC. 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. 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 or communicated with eight people who used the service and four relatives about their experience of the care provided. People who were unable to talk with us used different ways of communicating including Makaton, symbols, objects and their body language. We spoke with nine members of staff including the registered manager, regional operations manager, deputy manager, senior support workers and support workers. We spent time observing the support and communication between people and staff in shared areas of the house.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eight people's care records and three medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We sought urgent assurances from the provider as to actions they were taking with regards to the risks to peoples dignity and respect. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted three professionals who have regular contact with the service.

Inadequate

Is the service safe?

Our findings

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

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

- People were not kept safe from avoidable harm because staff and managers failed to report and manage incidents safely. This included when people were distressed which had resulted in incidents of self-injurious behaviours. We observed one person hitting their head on several occasions during the inspection. We spoke with the registered manager to check what was in place to support this person when they were upset. The registered manager told us, "We refer to our Health and Wellbeing team if we feel we need Positive Behaviour Support (PBS)." This person had not been referred to the PBS team. The registered manager told us, "It's something [person] does all the time". Staff described this as occurring potentially daily. One staff member said, "Sometimes [when person] bruises we put that in the daily diary, [person] does it when in a bad mood." The provider could not be assured people lived safely as risks had not been assessed, mitigated or monitored.
- The service did not promote a culture of incident reporting and as a result had failed to manage people's needs safely or learn lessons. Staff consistently told us incidents were not recorded, one said, "I asked but was told we are not expected to do incident reports, I have not seen any incident reports.". Another said, "I don't know about recording these."
- Staff shared further examples of how incidents of self-injurious behaviours were not managed safely. One spoke of another person who would bang their head repeatedly on a radiator, "[person] does that sometimes, we record in daily diary and give paracetamol". The registered manager said, "I have no system for checking daily records or handover sheets". This meant people were not safe from harm as incidents had not always been managed effectively or in line with the providers policy for Accident, Near Miss and First Aid. This defined incidents as, 'Any event that resulted in an adverse effect (however minor) on an individual supported, member of the public or team member. Service managers will ensure that processes are in place and embedded to support and encourage team members to report all accidents, incidents and near misses'. The lack of an open incident management process had resulted in a failure to ensure risks to people were managed safely. We reported these incidents to the local authority for consideration by the safeguarding team and informed the registered manager.
- Some staff told us they were reluctant to support someone to manage their dignity as they had previously bitten them. Records relating to people's keywork reviews documented staff being pinched and scratched. A keyworker is a staff member who has been assigned by the service to co-ordinate the support and care provided for the person who carry out regular reviews. These records had been reviewed by the registered manager however, they were unable to evidence how incidences had been managed or that any subsequent actions were taken to mitigate risks and share lessons learnt.
- The provider did not always manage the safety of the living environment and equipment. Staff told us people enjoyed spending time in the garden. Environment checks had failed to identify the need to arrange for broken kitchen appliances to be removed from the garden to minimise risk to people. We spoke to the

registered manager who arranged for this to be removed immediately.
● People, including those unable to make decisions for themselves, did not have as much freedom, choice and control over their lives as possible because staff failed to manage risks to minimise restrictions. We saw some people using wheelchairs indoors. Records relating to mobility for one person noted a health professional had advised staff to encourage the person to walk around the house and to use the wheelchair when going out only. We saw this person was sitting in the wheelchair, wearing a lap belt, this reduced their ability to have control over where they wished to be. We asked staff about this, one told us, "There was no reason for a wheelchair indoors, they used to grab at food and others so are in the wheelchair". The provider shared details of an assessment they had completed noting the person making this decision. The rationale for this decision was not clear to staff and conflicted with the advice of a health professional. The service had failed to ensure the rationale for decisions managed risks which minimised the need to restrict people's freedom to keep them safe.

The failure to assess, record and mitigate risks to people's health and safety was a breach of regulation. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment)

The provider has told us of their plans to support the service to improve how risks were being managed. This included additional management support and input from the providers Health and Wellbeing team.

● Through the inspection we observed staff interacting with people. People were relaxed with staff and spoke positively about the service and the staff.
● One person said, "The staff are good here". One relative told us they felt their loved one was safe, "The manager and deputy manager kept the place running they lead very well".
● Staff had completed Personal Emergency Evacuation Plans (PEEPs) for people which included consideration of specific risks. The registered manager spoke of their plans should they need to evacuate people in the event of an emergency. People's records included clear instruction on how to use evacuation equipment. This provided assurance risks to people from fire were being assessed and managed effectively.

Staffing and recruitment
● The service did not have enough staff to meet peoples assessed needs. Three people had been assessed for one-to-one support during the day, several people required two staff members to provide personal care and seven people required support with meals.
● We observed one person who the provider had assessed as requiring 1-1 support during the day waiting in the dining room. The provider had informed us due to their medicine requirements they had to wait for a set period of time between taking their medicine and eating their meals. We observed this person sat in the dining room, whilst other people ate for 45 minutes, without their 1-1 staffing. The deployment of staff had not considered the impact of this on this person.
● Staff consistently told us there was not enough staff, one said, "We average four on a shift, it has been three". Another told us, "It can be really difficult when things happen at the same time". Relatives also shared their concerns, one said, "They haven't got enough staff, experienced staff are leaving".
● One relative told us, "There has been occasions when the low number of staff was one of the areas we spoke to registered manager about. Also, when care staff in the house don't drive and don't want to drive".
● The skills of staff did not always match the needs of people using the service. Observations of staff did not provide assurance of their knowledge and skills supporting people with their communication needs. Records relating to communication identified some people using Makaton, a form of communication which, 'Uses symbols, signs and speech to enable people to communicate.' We observed people communicating with Makaton, however, did not see staff responding. One staff member said, "They had never heard of it".

Another spoke of a Makaton file in a cupboard. This meant people could not be assured staff responded to their communication in a manner which confirmed they understood the signs people used.
● The registered manager told us how shortages in staffing and recruitment challenges had impacted on their ability to ensure people had opportunities to take part in activities. "There have been no applications coming though, we have a shortage of drivers and this has impacted on our ability to take people out." They went on to say, "We have ensured people have attended their appointments".
● The service did not have a systemic approach, or coordinated understanding, of the levels of staffing required. Some people required different levels of funded one to one support. The registered manager had been aware of this requirement yet staffing levels on weekly schedules had not reflected this. This resulted in people not being supported or able to take part in activities and visits how and when they wanted. This meant people were not receiving the support they required to ensure they remained safe and well cared for.

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action following the inspection to increase staffing levels. They informed us they had reviewed the rota and were arranging for agency staff to cover staffing shortfalls. Following inspection we were told the service had reflected on supporting people to eat and had reviewed the length of time people would be waiting in the dining room for a meal.

● Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people.
● Every person's record contained a clear one-page profile with essential information and dos and don'ts to ensure that new or temporary staff could see quickly how best to support them.

Systems and processes to safeguard people from the risk of abuse
● People were not always safe from abuse. Systems and processes to protect people from the risk of abuse were not operating effectively. For example, when incidents of allegations of abuse were known, they had not been reported to the local authority safeguarding team or CQC. Staff spoke of an incident where shortfalls in staff practice may have resulted in an injury to a person. The registered manager took action to ensure the person received medical attention and followed this up with the staff member concerned. They failed to identify this was an allegation of abuse reportable to the local authority and CQC. The provider could not be assured safeguarding systems and processes were operating safely or identifying potential allegations of abuse.
● Managers and staff had failed to consider incidents within safeguarding processes. Staff had described incidents occurring including unaccounted for bruises, self-injurious behaviours and allegations of biting and pinching which had not been recorded or reported this resulted in a lack of external scrutiny or investigation.
● Staff had training on how to recognise and report abuse but did not always follow the providers safeguarding procedure which included the need for staff to, 'Report anything, they witness which is or might be abusive or harmful'. This failure to identify concerns increased the risks to people from harmful or abusive incidents as these had become "Normalised" within the service.
● During the inspection we raised three alerts to the local authority for consideration within safeguarding

processes which had not been previously identified or raised by the managers or staff at the service.

The registered manager had failed to raise safeguarding alerts regarding allegation of abuse. The provider had failed to ensure that staff safeguarding awareness ensured people were adequately protected from potential abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following inspection, the provider and registered manager provided assurances they would ensure allegations of abuse were reported to the local authority safeguarding team and notified to CQC.

Using medicines safely

● Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating and when assessing risks of people taking medicines themselves. We observed staff supporting a person with medicine which demonstrated an awareness of the persons individual needs.

● People received their medicines safely in accordance with the prescriber's instructions. 'As required' medicine (PRN) had protocols in place to guide staff describing what the medicine was prescribed for and included details such as dose instructions, signs and symptoms. The deputy manager told us how they kept protocols under review and worked with the pharmacy and surgery to ensure these remained current.

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. Staff had ensured people's medicine were regularly reviewed with health practitioners.

● People were supported by staff who were trained and followed systems and processes to prescribe, administer, record and store medicines safely.

Preventing and controlling infection

●The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had effective arrangements to keep premises clean and hygienic. Staff told us they supported people to look after their rooms whilst staff at night cleaned communal areas.

● The service tested for infection in people using the service and staff. They also demonstrated a commitment to supporting people to receive the COVID-19 vaccine.

● The service had a system to monitor the vaccination status of staff and check the status of visitors.

● Relatives spoke positively about how staff had supported their loved ones through the pandemic. One told us, "During the pandemic a phone or iPad was brought to [person], we did facetime quite a lot".

● The service prevented visitors from catching and spreading infections.

● The service followed shielding and social distancing rules.

● The service admitted people safely to the service.

● Staff used personal protective equipment (PPE) effectively and safely.

● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.

● The service's infection prevention and control policy was up to date.

● The service supported visits for people living in the home in line with current guidance.

● All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

Inadequate

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● CQC would expect providers of services for people with a learning disability and autistic people to demonstrate how they are complying with the principles of right support, right care, right culture guidance.
● People did not receive care and support which complied with recognised models of care. The British institute of learning disabilities (Bild) describes how the positive behaviour support (PBS) approach promote people's quality of life. PBS is about working in partnership with people. Treating them with dignity and respect and enabling them to have a better life. All behaviours have a meaning… Positive behavioural support is an approach that put the person at the centre to make systems work for the person. (Bild definition of PBS). Observations of staff evidenced significant shortfalls in the quality of support people received.
● We observed a person being spoon fed a meal, staff interacted with them positively. A review of their support plan noted the person needed encouraging, however was able to eat independently. Staff had failed to promote this person's independence and did not provide support in line with their assessed needs or respect their choices. A staff member confirmed people choices were not always considered, when talking about clothes they told us, "I choose myself, [person] doesn't choose". The provider could not be assured people were supported in line with their assessed needs and choices.
● Support plans did not always reflect people's range of needs; sensory needs had not been assessed. One person had a sight impairment this was identified through a review of their record. The provider had not assessed this need or provided guidance for staff to support this person with this need or any consideration of potential impact this may have in other aspects of their life.
● Records did not provide relevant information for staff. For example, risk assessments had not offered guidance to support a person when they experienced distress. Staff told us this was often a daily occurrence. Staff were observed offering support in a respectful manner however, the lack of guidance increased the risk of people not receiving consistent support when they were experiencing distress. Staff told us they did not have any formal method to record what led up to episodes of distress, what was happening for the person or what supported them to manage this. One told us, "We don't do that… did have a bit recorded a couple of years ago". Another staff member described how they managed when a person displayed self-injurious behaviours, "Not sure why [person] does it I try to stop it by interacting with them". The provider failed to ensure they had an effective system to support people to manage emotional distress. Consideration had not been given to the function behaviours that may challenge others or self-injury may have for people and not sought or carried out functional behavioural assessments.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach

of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had health actions plans/ health passports which were used by health and social care professionals to support them in the way they needed and were supported to access healthcare services.

Staff support: induction, training, skills and experience

● The service did not have an effective system to check staff's competency to ensure they understood and applied training and best practice. We observed examples of poor staff practice, some staff could not always provide assurance they could effectively communicate with people. This increased the potential risks of not understanding their roles and responsibilities effectively.

● The registered manager informed us they completed regular checks however, this was not evident in the service. The deputy manager said, "I do competency checks because I am here all the time, not recorded but do raise issues with them". This did not provide assurance the service was recording or managing the support staff needed to develop their skills and maintain best practice.

● Not all staff had received training for people's communication needs. For example, several peoples support plans included reference to Makaton, a communication aid used by some people in the service. During the inspection we observed people using a variety of Makaton signs. Care plans did not include information about signs and gestures people used to express themselves or any guidance for staff in how to support people with this.

● Staff gave mixed feedback about their experience of supervision and support. One said, "I have had two supervisions and one appraisal in the last year". Another told us, "I have not heard of supervision". Some staff were unclear about supervision arrangements, one said, "Supervision is six monthly, that's the policy. I had one covered raising concerns". The providers HR development policy stated following completion of probation, "These are usually every 6-8 weeks with actions captured on your Development Support Plan." Records did not demonstrate staff were always receiving effective support and supervision in line with the providers policy.

The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's care and support was provided in a clean, well equipped and well-furnished environment which met people's physical needs. In addition to bedrooms people could access a variety of shared living spaces which included a dining room and lounge. People and staff told us how they enjoyed using the garden in the warm weather. The kitchen could only accommodate one person with staff support at a time due to the size of the room and had not been adapted for people who used wheelchairs. The environment had not always been considered or adapted in a consistent manner to meet people's needs.

● People personalised their rooms and were included in decisions relating to the interior decoration and design of their home. Every room reflected people's tastes and interests. We observed people spending time in their rooms enjoying spending time interacting with staff.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

● People were supported to eat and drink enough to maintain a balanced diet. People could exercise choice throughout the day and could access sufficient food and drink. Some people had individual dietary requirements. We observed staff consistently offering people food in accordance with their individual needs.

A staff member told us how they had supported a person to consider healthier choices, "I made a deal with [person] to eat more healthy things". They went on to demonstrate how they understood people's individual food choices.

● Relatives told us, "[Person] was putting on some weight we spoke to the registered manager about a healthy plan. They spend a lot of time preparing nice quality food."

● Specific dietary advice was available for staff to ensure people received food and drink in accordance with guidance. This included people assessed as requiring modified diets.

● One person lived with diabetes and staff were knowledgeable about their specific nutrition needs. A health professional provided positive feedback, "The staff within the home are always friendly and approachable. They support [person] with diabetes care and have been proactive with improving their wellbeing physically and emotionally". Records relating to health needs were detailed and provided effective guidance for staff.

● People were referred to health care professionals to support their wellbeing and help them to live healthy lives. Managers and staff demonstrated an effective understanding of people's health needs and were working closely with health professionals when needed.

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.

● Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards. However, staff were not consistently applying the principles. For example, staff could not be confident that people had all the information they needed and understood the consequences of their actions before making their decision. We cover this aspect in detail in the Caring domain.

●Records confirmed capacity assessments had been completed and people and those important to them were involved in best interest meetings. Relatives told us, "Any concerns they would contact you".

● People had an authorised DoLS and the registered manager had a system to follow up with the local authority when it was due to expire.

Inadequate

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated with dignity. One person was not receiving the care and support they needed to ensure their privacy and dignity needs were met. We observed the person in an undignified state of undress for the majority of our inspection which took place over the course of three separate visits. This took place in shared areas, for example, on the ground floor in the hall outside of the kitchen and in sight of the front door. On our second visit we witnessed staff answering the door to a visitor with this person sitting on the floor behind them in a state of undress. Staff did not consider the persons dignity or make any attempt to support the persons modesty. This placed them and others at risk of harm.
- The provider had not ensured the person understood the consequences of their decision to not wear clothes or the impact this had on others. They had failed to advocate on this person's behalf to ensure they received support to manage this in a way which maximised they choices whilst respecting their privacy and dignity.
- Support and risk plans did not include details of the extent of this behaviour and tended to underplay the significance of it. Managers had not recorded methods to support the person with this sensory need. The regional operation manager told us a referral had been made to the providers Health and Wellbeing team in 2020. However, due to the pandemic this work had not progressed. A referral had been made to health professionals in September 2021 however, this had not been followed up. There were no interim support plans in place. This resulted in a failure to assess this person's needs, continued lack of guidance for staff and continued failure to manage privacy and dignity.
- Staff were not recording when incidents occurred or carrying out any form of analysis of the function of this behaviour for this person and as a result had continued to not manage their dignity or considered the impact on others living or visiting the service. We observed staff moving around the person carrying on with other tasks without taking notice of them on the floor in a state of undress. We saw staff supporting the person with personalised activities whilst they were not wearing clothes. Staff did not attempt to protect the persons dignity or identify this as a concern. The area operations manager told us," They hoped this behaviour wouldn't become normalised". From our observations and feedback from staff and visitors this had become "normalised". One relative said, "Staff have got blasé to them sitting in the hall with no clothes on".
- Staff consistently told us this had been happening regularly for some time. Their comments evidenced the impact this behaviour was having. Their comments included, "No discussion about [person] and clothes, not seen anything of a plan to help them". "[Person] bit me when I tried so I don't try now." "Person used to

wear a fleece and black leggings, don't know what happened things changed about five years ago, [person] will get dressed to go out. [person] has bitten me and drew blood". The provider had failed to ensure staff received guidance and support to manage a known risk to the persons dignity needs and as a result they remained left in undignified situations on a regular basis.

● People's privacy was not always respected. We observed and were told how other people had been affected by the needs of one person. We saw a person going into other people's rooms whilst being in a state of undress and were told by staff people didn't mind. One person said, "I do try (to keep them out) but I can't stop them. If I ask them to go [person] doesn't go". One person was unable to have a private conversation in their room as the shutting of their door caused distress to the person and this resulted in them having to have their conversation in a shared space. One relative described the impact of this, "During lockdown they put a chair against their door". We were also made aware a person had been on a video call when the person came into their room unclothed. The relative went on to tell us they had stopped asking managers to resolve this.

● Relatives expressed their concerns on how this had affected visiting others in the home. One told us how they wouldn't bring young relatives to visit their loved one because they would be embarrassed by the persons nakedness. Another spoke of how this had impacted them, "I did feel uncomfortable and my husband doesn't want to come as he finds it uncomfortable".

The provider failed to ensure people were treated with dignity and respect. Staff failed to ensure people's privacy was maintained. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We reported these concerns to commissioners and sought urgent assurances from the provider to detail the actions they were taking to seek specialist support, assess, mitigate and manage the risks to people. Following inspection, the provider has implemented interim measures whilst they continued to address the concerns raised.

● People had regular keywork meetings with staff to express their views. The registered manager told us monthly group meetings hadn't been effective for people and they were working with staff to improve the level of information the keyworking sessions captured to ensure the views of people were considered.

● Generally, people received kind and compassionate care from staff who used positive, respectful language which people understood and responded well to. Staff spoke respectfully of people and demonstrated genuine regard. They knew peoples likes and dislikes and supported them in a caring manner.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff did not always follow guidance in people's communication plans. Plans generally reflected people's needs and included communication assessments detailing how people communicated including actions they may take when happy or upset. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care. We observed people attempting to communicate with staff, we saw, one person moved themselves into the middle of the room and looked at the staff member. The staff member did not respond. This person then pulled a chair across the floor, again the staff member did not respond. The person then started to hit themselves on the head, it was the third attempt to communicate, the staff member responded and provided support. This person's support plan had noted they would hit their head if they were unhappy. The failure of staff to understand this person's communication sooner had resulted in an increased risk of self-injurious behaviour.
● People were not always supported with individual communication plans/ passports that detailed effective and preferred methods of communication. Experienced staff knew people's individual signs; however, the service had not developed the communication sections in some people's support plans to identify the use of augmented/other methods of communication such as Makaton and pictures and which signs or pictures the person uses at the current time and how this is being further developed or include steps for staff to follow.

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; Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Mangers and staff did not always work in a person-centred way to meet the needs of people with a learning disability and autistic people. They did not always follow best practice and the principles of Right support, right care, right culture and were not ensuring that these principles were carried out.
● People were not always supported to participate in their chosen social and leisure interests regularly. One person said, "When they are short staffed, they ask me not to do things I used to do". Staff and managers told us how staff shortages had impacted on the service. One staff said, "We make sure everyone is watered and fed and we all pull together, but we can't get everyone out if they want to, we need five or six staff to do that". Records relating to aims and goals had noted several people enjoying the benefits of swimming. Risk

assessments had been completed which identified the need for people to be supported by two staff in the pool. A Staff member told us, "I have raised about swimming and activities with the manager, it never happens". The registered manager had not been able to arrange for staff to support people with this interest following the reduction of lockdown measures. They told us they were under the impression there were remaining restrictions for people. We checked this situation and informed the manager there were no remaining restrictions. The registered manager told us they would assign staff to look into this with people.

● Some relatives told us the service had not had enough staff to provide support with activities. One said, "[Person] has not been able to take their car out since September 2021 because of a lack of staff, in particular drivers". They told us how they were coming in to support their relative with this. This meant the service was not always supporting people to access activities of their choosing.

● People were not always provided with opportunities to develop goals and aspirations. Staff did not always use person-centred approaches. We observed staff supporting people with meals, on several occasions this was task focused and there was a lack of communication with the person about their meal or opportunity for the person to engage and make choices. Support plans did not always include consideration of people's goals or aspirations and as a result missed potential opportunities for people to develop their interests and increase their independence.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who were living away from their local area were able to stay in regular contact with friends and family via telephone/ skype/ social media. Relatives told us, "During the pandemic we would Skype once a week". People were supported to visit family members, one told us, "[Person] is so happy when you bring them home and bring them back when coming up to the Worthing sign, they get louder and louder by the time they get there they are screeching". This provided assurance people had received support to maintain relationships.

Improving care quality in response to complaints or concerns

● People were not always able to voice concerns, and a relative told us they had not been confident to raise concerns as they felt, "There was no confidentiality at all". They spoke about an example where they were aware everyone had been told about it. Some staff echoed this view, one said, "I asked for [support] from manager but then everyone seemed to know about it". The service was unable to evidence they had treated all concerns and complaints seriously, investigated them and learned lessons from the results. The lack of confidence and trust had impacted on the culture of the service where a lack of openness and transparency had prevented people and relatives from voicing concerns.

This is an area in need of improvement. Following our inspection, the provider had informed us they were meeting with all relatives to understand their views with the aim of improving the quality of the service.

End of life care and support

● Staff were not currently providing end of life support, however, records confirmed they had considered peoples preferences should they be required.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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; 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; Continuous learning and improving care

● Governance processes were not effective and did not always keep people safe, protect their human rights and provide good quality care and support. The providers quarterly quality audits had not identified concerns about a person's dignity or considered the impact this was having on others living and visiting the home. This had resulted in a culture within the service which had "normalised" this practice and failed to respect the dignity and privacy of the person or others. One relative explained the impact for them, "It's just not right."
● The provider/ registered manager and senior staff were not alert to the culture within the service and were unable to evidence how they had sought the views of people and relatives or acted on any feedback.
● The provider had failed to ensure that all managers and staff promoted people's basic human rights. There was a consistent failure to ensure a person's need was met in a manner which promoted their dignity and privacy. Support plans did not provide guidance for staff or assurance on the accuracy and openness of the information. We observed and were told this need impacted on the person and service most days, however the support plan noted this as something which might occur occasionally. This resulted in an ongoing failure to seek professional support for a need which had a clear impact on the person and everyone in the service.
● The provider had not ensured management and staff understood the principles of good quality assurance. For example, incidents were not reported or analysed and did not include lessons learnt to inform practice development. Staff spoke about incidents where people may have experienced distress, on occasion this resulted in physical aggression towards other people and staff. Records relating to care were unable to provide evidence people had been supported effectively when upset. The service had not completed an analysis of incidents which would have supported staff to understand what may have led to the persons distress and identified strategies and techniques to support the person. Quality audits had not identified incidents had not been reported and had failed to identify the significant shortfalls with reporting and managing concerns.
● Senior staff failed to understand their responsibilities with regulatory and legislative requirements. During the inspection, we identified three incidents which we reported to the local authority safeguarding team. The registered manager and provider had not always ensured the local authority or CQC was notified of

incidents which were allegations of abuse. This meant the provider could not be assured all incidents had been reported to appropriate bodies and as a result had failed to ensure these had been managed safely or provided assurance of how they acted on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

●The governance of the service lacked a coordinated approach to ensuring people had enough staff to keep them safe. Staffing levels were consistently below people's assessed needs. This meant that people did not receive the care they had been assessed as requiring to keep them safe and provide them with the care they needed. The registered manager and staff spoke of staff shortages which had impacted on the quality of the service. They told us of several experienced staff leaving and the ongoing challenge to recruit. Staff consistently told us why recruitment was a challenge, one said, "For the money they won't come". Another told us, "Money is an issue its very low pay".

● Staff told us they didn't feel respected, supported or valued by senior staff this impacted on the service's ability to provide a positive and improvement-driven culture. One staff member said, "So many managers in the 10 years, current one hardly ever here. They don't know us, …really good staff have left". Staff told us their opinions were not always listened to or valued. One told us about their experience of staff meetings, "We are disheartened, sad because it's a nice home, we used to be asked to give ideas, can't be bothered now." The registered manager was responsible for two services and staff consistently told us they felt the manager did not visit 1 Charmandean Road enough. One told us, "Managers should lead by example, if they are not here that's not happening. They are not here a great deal, some weeks not at all. Need a manager here, not just once a week for a couple of hours."

● Senior managers did not always monitor the culture of the service and the potential need to challenge staff practices. On the second day of inspection we saw a staff member had placed their mode of transport in a persons room. We spoke with the registered manager who told us this sometimes happened. They had failed to consider the potential impact on the person or how this practice failed to promote a person centred culture within the service.

● The provider failed to set a culture that valued reflection, learning and improvement. The registered manager told us they did not have any formal staff competency checks. The lack of oversight processes had failed to provide staff with value-based competency assessments of their practice. For example, we identified how management had failed to monitor staff practice when supporting people with meals. On several occasions we observed staff failing to interact, make eye contact or talk to people whilst providing support with a meal. This resulted in the increased risk of people not receiving person centred support.

● Some staff told us they didn't feel able to raise concerns with managers without fear of what might happen as a result. They told us they didn't trust how confidentially would be managed. This increased the risk staff would not act in an open or transparent manner when things went wrong.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider informed us of actions they had taken to improve the oversight of the service. This included seeking the views of relatives and additional management support for the service.

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

● The registered manager was seeking to improve the involvement of people and those important to them. They had maintained contact with families throughout the pandemic and shared a regular email with them. This ensured relatives received regular updates from the service and had an opportunity to provide feedback.

● Staff encouraged people and relatives to be involved in the development of the service. One relative told us about their experience when a loved one moved into the service during the pandemic, "Person chose the colours for their room. [Staff] involved them in as many choices they could make. I am pleased with all the members of staff. I can ask any member of staff a question, if they don't know the answer they will go and find out."

● Staff had developed positive working relationships with a range of health and social care professionals. One health professional told us staff had, "A proactive approach in supporting [person], including specialise blood sugar monitoring, urinalysis monitoring and collection. They have also been working closely with the diabetes nurse specialist and the practice nurse. If they are unsure of anything, they will contact the district nurses or GPs in a timely manner."

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 The provider failed to ensure care and support was appropriate to meet people's needs.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. Staff failed to ensure people's privacy was maintained.

The enforcement action we took:

Warning Notice

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, record and mitigate risks to people's health and safety. Incidents were not being managed safely or in accordance with the providers policy

The enforcement action we took:

Notice of Decision

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 registered manager had failed to raise safeguarding alerts regarding allegation of abuse. The provider had failed to ensure that staff safeguarding awareness ensured people were adequately protected from potential abuse.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs

The enforcement action we took:

Notice of Decision