

Country Retirement & Nursing Homes Ltd

Glebe Farm

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

About the service

Glebe Farm is a residential care home providing personal and nursing care to up to 9 people aged 18 and over. Four people were living at the home during our first two visits. A fifth person was admitted prior to our third visit.

Each person living at Glebe Farm has their own one-bedroom flat. There are three buildings surrounding an enclosed courtyard. Each building has three flats and some shared spaces. One flat has its own enclosed garden.

Although this is a new home, it is registered to support nine people, which is larger than current best practice. The provider worked closely with the local authority during the planning stages and designed and built a home to meet the needs of specific individuals who have very complex requirements.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people.

The service did not support people effectively in line with positive behaviour support principles. Staff were not suitably trained to support people using positive behaviour support.

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

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

Staff had not always supported people to carry out activities that were meaningful to them. Support plans

were not person-centred and did not give staff enough guidance to ensure that they knew how people wanted their needs met.

People were not always safe. There were not always enough staff deployed to support people, so people and staff were at risk of harm. The correct safeguarding procedures had not always been followed. Risk assessments were not always in place or did not contain personalised information staff needed to keep people safe. There was not an effective system in place to learn lessons from incidents or accidents.

Leadership of the service was poor. The provider had not ensured that quality assurance systems were robust enough to identify and rectify shortfalls. The management team had not always worked collaboratively with external health and social care professionals. People, relatives and others were not asked for their views about the service. Staff felt their views were not listened to.

There were not always enough staff with the right knowledge, skills and experience deployed to ensure that people's holistic needs were met. Staff had not received suitable induction, training or support to ensure they were able to effectively meet people's needs.

There was not a caring culture in the home. Relatives and external professionals told us that most staff were caring, kind and tried to do their best for the people they were supporting. We saw that most people were comfortable with the staff and enjoyed their company.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not always support this practice. People's choice of what they wanted to do was not always met.

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

Rating at last inspection

This service was registered with us on 30 August 2018 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns raised by a whistle-blower and by the local authority. The concerns were about staffing levels; staff training and competence; care planning; lack of activity; and poor management. A decision was made for us to inspect and examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report. Some actions have already been taken by the provider to reduce risks. Following the inspection the provider told us that they had changed the management arrangements. Additional training for staff is planned.

Enforcement

We have identified breaches in relation to governance, safe care and treatment, staffing, person-centred care and notifications at this inspection.

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Glebe Farm

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 site visits on 3 and 15 July 2019 were carried out by two inspectors. On 6 August 2019 one inspector and an inspection manager carried out the visit.

Service and service type

Glebe Farm 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 the inspection

We looked at information we had received about the service since its registration. We sought feedback from the local authority and external 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 this information to plan our inspection.

During the inspection

During our site visits we met or saw four of the five people who were living at the home. Due to their complex

requirements they were not able to give us any feedback about the service they received. We saw how people interacted with staff. During our three visits we spoke with 10 staff: two support workers; two nurses; the administrator; the maintenance person; the registered manager; the operations manager; the operations director and the director of quality.

We received feedback from several health and social care professionals involved with the home. As part of the inspection we spoke with three relatives and four staff over the telephone. We looked at a range of records, including audits, staff meeting minutes, staff personnel files and accident and incident records.

After the inspection

We continued to seek clarification from the registered manager, the provider and external professionals who regularly visit the service. We completed the inspection on 15 August 2019.

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing

- The provider had not deployed enough staff with the necessary knowledge, skills and experience, to fully support people in the way they needed and to keep them safe. On the days we visited some activities had not taken place, for various reasons, including not enough staff to support people two-to-one in the community. Staff told us this happened often.
- One person's relatives told us there had been occasions when they had arrived at the home for a planned visit and the registered manager had told them there were not enough staff for them to safely visit their family member.
- An external professional told us they had arrived to deliver a planned training session and only three staff could be released from supporting people. A member of staff said they had missed training sessions because there were not enough staff to provide the one-to-one staff each person needed if they did the training.
- Staff told us they did not always feel safe, especially at night. They said this was because there were not always enough staff. On occasion staff had had to call the emergency services (police and/or ambulance) because there were not enough staff to manage a person's anxiety.
- The registered manager had not always ensured staff had sufficient breaks and sometimes they worked without a break throughout a 12-hour shift. One member of staff told us about a day they had not eaten their dinner "because it's so busy and I haven't been able to stop." Another member of staff said the long shifts "are very draining...it can feel like you haven't had a day off." This meant there was a risk that their ability to function safely could be impaired.

Systems and processes to safeguard people from the risk of abuse

- The provider had systems in place to protect people from abuse and avoidable harm. However, these were not always followed. Staff had undertaken training but had not been made fully aware of their responsibility to ensure that any concerns were correctly reported and dealt with. They told us they would report any concerns to the senior member of staff on duty. They were not all aware that they could report outside the service, for example to the local authority, if no action was taken.
- The registered manager had not always made appropriate referrals to the safeguarding team. Following an allegation of serious abuse, they had carried out their own investigation and had decided there was no evidence of abuse. This is contrary to the local authority's safeguarding protocols, which meant there was a risk that people were not always protected.
- The registered manager had not always notified CQC when safeguarding referrals had been made about the service by other agencies, such as the hospital.

Assessing risk, safety monitoring and management

- The provider had not ensured that risks to people were assessed, monitored and managed, which meant people were at risk of avoidable harm. Some basic risks to people had been assessed and some guidance put in place for staff. However, written risk assessments were not personalised and some risks had not been considered. For example, there were no risk management plans for each person when they were accessing the community.
- Some risk assessments recorded in one person's care plan did not give accurate information. For example, no specific risk had been noted for nutrition yet the person was on medicine to help them put on weight.
- One person was not safe at the service as they had had a high number of hospital admissions following incidents of self-harm. The local authority learning disability partnership had been working with the staff team to try to improve this person's safety. However, the provider's lack of a 'lessons learnt' structure meant that support staff had not always been given sufficient guidance to prevent incidents.
- People were not supported to take positive risks. An external professional told us that the staff team were reluctant to take any risks. Staff had admitted to them that their reluctance was based on their lack of confidence in their skills and was to avoid any incidents. This meant people would not be able to develop their daily living skills.
- Staff told us that risk assessments were not available to them on their hand-held devices so they were not able to access them when needed.

Learning lessons when things go wrong

- Lessons had not always been learnt. The provider did not have a system in place to ensure that lessons were learnt from incidents. Records showed that a high number of incidents had occurred but any learning had not been shared with the staff team. This meant there was a high probability that the incidents would recur, putting people at risk.
- A senior member of staff confirmed that there was no formal process for sharing learning. They told us, "I don't know why, we used to have 'lessons learnt' meetings in my previous job."
- The registered manager had failed to make a safeguarding referral following an incident involving a member of staff. This had placed both the person and the member of staff at risk. About two months after the first incident another member of staff alleged that a similar event had occurred. This meant there had been insufficient learning and action following the first incident to prevent it happening again.
- A senior member of staff agreed to one person's request to go to an evening activity that was not planned. They sent a member of staff the person did not get on with and an incident occurred, which ended up involving the police, other staff and the person having to attend hospital.
- A number of new staff had left. One member of staff told us this was because senior staff had not learnt that staff needed more training and more support. The registered manager confirmed that there were currently no opportunities for staff for reflection or learning from incidents other than a quick de-brief with the senior staff member on shift following the incident. Staff told us that even this did not always take place.

Due to lack of staff, people were not always fully supported and there was a risk that both people and staff were not safe. The correct safeguarding procedures had not always been followed. Risk assessments were not always in place when needed or did not contain the personalised information staff needed to keep people safe. There was not an effective system in place to learn lessons from incidents or accidents. All the above places people's health, welfare and safety at risk. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received fire safety training and knew how to support each person if they needed to leave the building in an emergency. Fire safety systems such as alarms and emergency lighting were tested regularly.

Recruitment

- Information about some agency staff was not sufficiently detailed for the registered manager to be sure that the agency staff member was suitably checked and qualified. There was no date or signature on some agency staff profiles, which meant the information might not have been up to date.
- The provider had a recruitment procedure in place, which staff told us had been followed when they had been appointed. They said pre-employment checks including references and a criminal records check, through the Disclosure and Barring Service (DBS), had been in place before they started working with people.

Using medicines safely

- The provider had systems in place to make sure that medicines were managed safely. However, these had not always been fully effective.
- Some support staff had been trained to give people their medicines. The registered manager said the nurses had signed these staff off as competent. However, not all nurses, especially the agency nurses, had had their competence assessed.
- We were notified about an error in medicine administration made by an agency nurse. Staff had not sought medical advice until a few days after the incident.
- Staff had completed medicine administration record (MAR) charts to show that medicines had been given as prescribed. Medicines were stored safely.
- There were protocols in place for medicines prescribed as 'when required'. Staff had recorded why the medicine was needed on the reverse of the MAR charts. We checked three medicines in their original packets and the number of tablets remaining tallied with the records. Staff told us they counted all tablets twice a day to make sure they were correct.

Preventing and controlling infection

- The provider had systems in place to make sure that staff practices controlled and prevented infection as far as possible. Staff had undertaken training and were fully aware of their responsibilities to protect people from the spread of infection. The home was very clean.
- The registered manager told us that an infection prevention and control champion had been appointed. This member of staff would be monitoring all aspects of hygiene and cleanliness throughout the home, ensuring staff followed good practice guidelines and cascading updated information to the staff team.

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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider had not ensured that staff had received the training and support they needed to enable them to effectively meet people's needs. Staff had not undertaken sufficient, appropriate training or induction. Most staff had had training in topics the provider considered to be 'mandatory'. These included moving and handling; fire safety; infection prevention and control; food hygiene and first aid. However, one senior member of staff told us they had not done some of the 'mandatory training' such as food hygiene or first aid even though they had worked at the home for about nine months.
- The provider had not organised training for staff in topics specific to the people who were living at Glebe Farm. For example, staff had not received training in autism despite the provider advertising Glebe Farm as a specialist autism service. One member of staff told us, "I've not had specific training in autism but I have done my own research in my own time." Training had not enabled staff to fully understand the use of positive behaviour support (PBS). PBS is a person-centred approach to supporting people who display behaviours which challenge.
- Although some staff had attended a training session relating to supporting someone with a complex and specific health condition, staff had not put the training (or the person's support plan) into practice. As such the person had put on a lot of weight and their behaviour had become more challenging to themselves and others. A senior member of staff said, "Staff were feeling quite intimidated... We are asking a lot from [staff] when they have not had the training or the experience with this."
- The provider was unable to demonstrate that they had followed their own induction policy, which required that new staff had their competence assessed before being allowed to work alone. The local authority found that the induction offered to new staff had not been robust enough to induct them appropriately into the role.
- New staff, especially those who had not previously worked in a care setting, had not been inducted, trained or supported well enough to ensure they were comfortable working alone and providing effective care to people with very complex support needs. The service had seen a high turnover of staff, including a high number of new staff leaving. One member of staff said, "Sometimes it's just that it's a shock to the system....not what they were expecting." The provider did not demonstrate that this had been analysed and addressed.
- Staff did not feel supported by the management team and did not feel adequately trained to be able to do their job well and keep themselves and the people they were supporting safe. Support staff received supervision from the nurses. Nurses had not received supervision when the registered manager had been on extended leave and phased return to work.

Staff were not sufficiently competent, skilled or experienced, nor were they deployed effectively to fully meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had their needs assessed by their social worker and by the registered manager, before they were considered for a place at Glebe Farm. They then had a period during which they got to know a small team of staff and visited the service. The format and length of this period varied depending on each person's individual needs.
- However, the provider had not ensured that staff were sufficiently trained and supported to achieve effective outcomes for people. On their website, the provider stated, 'Glebe Farm was set up with the purpose of avoiding the "revolving door scenario" whereby placements for people who are discharged to more standard residential services or supported living type environments from hospital, break down often resulting in re-admission to hospital.' One person had already left the home and another had been given notice to leave (although at the time of the inspection this had been put on hold while the local authority worked with the staff to try and reverse the deterioration in the person's health).
- Staff told us about the person who had left and said they had not received adequate training or support for them to understand and care for the person. This meant that care had not been delivered in line with best practice guidance.

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

- Prior to the inspection we had received concerns about the way the provider was managing one person's specific needs relating to food and drink. People had not always been supported to eat a healthy, balanced diet, in line with professional advice. Some improvement had taken place: however, this was still work in progress.
- One person had a specific condition that required staff to assist them fully with their nutritional and hydration needs so that their weight was managed. Lack of appropriate dietary support had resulted in the person putting on a lot of weight.
- At the time of the inspection staff assisted people to prepare their own meals in their own flat and gave them a choice of food at each meal. In this way, staff were managing the risks associated with food and drink better than previously.

Staff working with other agencies to provide consistent, effective, timely care

- Teams from the local authority's Learning Disability Partnership (LDP), including social workers and learning disability nurses had been working with the staff for several months to try to improve the care and support provided to people. Initially there had been some resistance from the management team at Glebe Farm, but at the time of the inspection staff were working well with the LDP.
- One person was having numerous admissions to hospital. The registered manager told us they had liaised with the hospital learning disability nurse to try to improve the person's experience whilst at the hospital.

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

- Glebe Farm was designed and built to bring people with complex needs who were living in homes or hospitals in other counties, back to Cambridgeshire. The provider and the local authority had worked together to design appropriate accommodation for each person.
- Each person and their relatives had been involved, as much as they wanted to be, in decorating and furnishing their flat. Each flat was personalised and included any specialist equipment that the person needed as well as the person's own belongings.
- A small farm had been developed in part of the extensive grounds. The registered manager told us that

people enjoyed going to help feed and look after the animals.

- Each flat opened onto an enclosed garden area and most people were able to walk around as and when they wanted to.

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

- Care plans showed that nurses took regular observations such as temperature, pulse, respirations and blood pressure. The registered manager did not know why they were doing this as the people living at the home were physically healthy young adults. We noted that when these observations had shown extraordinary results, such as a spike in pulse rate, no action had been taken. No action had been taken when a record of one person's weight showed they had lost over eight percent of their body weight in two weeks.
- External professionals told us that staff did not always follow their advice, to the detriment of the people they were supporting.
- A range of health and social care professionals were involved with each person. They worked with the staff team to support people to access healthcare services when they needed them.

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.

- Detailed assessments of people's capacity to make certain decisions showed that staff were working within the principles of the MCA. Staff had recorded these in people's support plans and made DoLS applications to the local authority when relevant. Each person living at Glebe Farm had DoLS authorisations in place, or applications had been submitted. The registered manager told us that none of the authorisations had any conditions. They were aware of when each authorisation was due to be renewed.
- Staff supported people to make decisions. Staff knew that one person got very anxious when they did not understand what was happening. So, they only offered a choice of two things (meals, drinks, activities and so on) so that the person could choose but not get anxious. However, people's choices, such as activities they wanted to do, were not always adhered to.
- Staff showed they understood the principles of the MCA. For example, they had taken a best interests decision that one person needed to wear a harness when travelling in the car in order to keep them safe.

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 requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had not shown a caring attitude to the people living at Glebe Farm, demonstrated by the shortfalls we found in the service being provided. Staff had not been given the tools they needed to provide a caring service to people, resulting in people not always being well-treated or well-cared for. Staff had not been trained to deliver effective care and support, and advice from professionals who knew individuals well had not always been followed. This put people at risk of harm and did not demonstrate a caring approach. An external professional told us that some staff lacked enthusiasm.
- We saw some staff had good relationships with people and people enjoyed their company. There were kind and compassionate interactions. Staff we spoke with seemed to genuinely care about people and wanted to do their best for them. A relative told us, "Some of the support staff have been great, they really know [name] and really gel with [them]." Another relative said, "All staff are supportive, empathetic and really caring. I feel they all want to do their very very best for [name]."
- An external professional told us, "I have observed the staff treating [people] with respect and compassion. Most [staff] have built good relationships with the [person] I work with."
- The language used by some staff (including the management team) in both written and spoken communication was not always appropriate. The provider's senior leadership team had not identified or tackled the management team's inappropriate use of language. This lack of good example had resulted in the language being used by some staff not always being appropriate. An external professional told us they had heard a support worker referring to a person "in derogatory terms". This did not show a respectful, compassionate or caring approach.

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

- Staff were encouraging two people who did not use words to communicate, to speak: they told us both people's speech had improved considerably since they moved to Glebe Farm.
- Staff supported people to make all their own decisions and choices. People were very able to let staff know if they did not want to do something.

Respecting and promoting people's privacy, dignity and independence

- Staff supported people to be as independent as possible. For example, staff encouraged people to help prepare their own meals. One person did their weekly supermarket food shopping with their relative and staff support so that they could choose their own food and drinks.
- Staff supported people to maintain their privacy and dignity as much as they were able to. People were well groomed and appropriately dressed. There were guidelines in people's support plans to remind staff to

give people privacy, for example if they were in the bath.

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.

Planning personalised care and support to ensure people have choice and control and to meet their needs and preferences

- People's support plans were not written to a standard that would enable a consistent approach for all staff to know how to meet each person's needs. The local authority had been telling the staff team this for several months and the registered manager told us this was being addressed. However, we looked at a printed copy of one person's support plan and found it was still not of an acceptable standard to provide staff with the information they needed to support the person consistently.
- Some information in support plans was contradictory and confusing. For example, in one person's support plan, three different documents gave completely different foods that the person liked for breakfast. This person's medical condition meant they could not eat certain foods, some of which were included. This meant there was a risk that the person would be ill if staff gave them the wrong food.
- Staff had failed to follow support plans and advice from professionals. For one person this had resulted in an increase in their challenging and self-harming behaviour. Another person had worked out how to make sure they were only supported by staff of their choosing. This had a detrimental effect on other people.
- The provider used an electronic system for support planning. The full support plans were available on computers in the two nurses' offices. Printed copies of the plans were extremely long: the one we were given was 93 pages. The registered manager said it was easier to find information on the electronic version. However, staff demonstrated that this was not the case. An external professional said, "The service is very pleased with its electronic record-keeping system, but this contains a lot of information and it is hard to draw out the basic information that you would need to support an individual."
- Each member of staff carried a hand-held device. This gave them access to some of the support plan and allowed them to make real-time records. The devices only retained information for the previous 48 hours. This meant if a member of staff had been off duty, they relied on other staff giving them information about the person they were supporting as they did not have time to look at the full support plan.
- The devices produced information in extremely small type, which staff found difficult to read. Information such as the person's likes and dislikes in relation to food and drink was difficult to find.

Supporting people to follow interests and to take part in activities that are socially and culturally relevant to them; supporting people to develop and maintain relationships to avoid social isolation

- People were not supported to take part in meaningful activities. One person's care plan stated, '[Name] needs to be kept busy throughout the day to minimise any anxieties or behaviours.' We saw that this person spent a lot of the time walking round the courtyard, in and out of their flat. Although there were staff present, the person was not engaged in any meaningful activity. Staff told us they took this person out for a drive. They did not get out of the car, just drove around, which was not responsive to their assessed needs.
- One person had a timer in their flat, which staff set to let the person know when the next activity would be

taking place. During one of our visits the person watched this for three quarters of an hour, waiting for a snack. Staff had not introduced any other activity to take place during that wait.

- One person's care plan included a range of activities they liked to do and places they liked to visit. The activities on the person's weekly activities planner did not correspond to their preferred activities listed in their care plan, including that they wanted to go to a religious service on Sundays.
- An external professional told us that staff avoided some activities because of the risks they perceived to be involved. On these occasions, staff had not provided people opportunities to be involved in alternative activities.
- Staff encouraged relatives to maintain contact with people living at Glebe Farm. Although for some people this was limited because staff and other professionals considered the person became more unsettled when they saw their relatives. One person's relative spoke with them on the telephone every evening.

End of life care and support

- Care planning for end of life support was not in place. This meant that if a person suddenly entered the final stage of their life staff would not know their preferences for how they wanted to be cared for.
- The registered manager told us they were starting to talk to people's relatives about end of life. They said that people's relatives found this very difficult because people were so young.

Failure to provide accurate person-centred information about the support people required meant that people were at risk of not getting their needs met in the way they preferred, including at the end of their life. People were not supported to take part in meaningful activities. This was a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- Each person's communication needs were detailed in their care plans. Staff used a variety of methods to communicate with people, based on the assessment of their communication needs. These included picture cards, word boards, electronic methods and by showing people choices.
- One person had not used words to communicate when they moved into Glebe Farm, although they understood simple instructions and could make choices. Staff and the person had worked hard and the person's speech had developed well. They now used several words to tell staff what they wanted.
- Staff told us that one person used a variation of Makaton (using signs and symbols to help people communicate). Staff had not undertaken Makaton training; one member of staff told us, "I learnt this through transitioning and in my own time."
- Care plans were not accessible to people. They were electronic and when printed were not available in a format that people using the service would be able to understand.

Improving care quality in response to complaints or concerns

- The provider had a complaints process in place so that people, their relatives and other interested parties could raise a complaint.
- The registered manager maintained a complaints log. This showed that they had not always responded to a complainant within the timeframe stated in the provider's policy.
- The registered manager had produced a leaflet in an easy-read format with pictures and symbols so that people might better understand how to make a complaint. However, this had been printed so that the inside pages were upside down, making it rather confusing.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had not ensured that there was good leadership in place at the service. The registered manager was not a good leader. Staff reported that a culture had developed in the home whereby they felt intimidated and unable to speak to the management team for fear of reprisals. External professionals reported that they had encountered resistance from the registered manager to work collaboratively with them.
- Staff did not always feel supported by the management team, especially after incidents during which they had been hurt. One member of staff said they had been injured while out in the community. They went back to the home and senior staff did not allow them any time to recover. They were immediately directed to support another person who was becoming very anxious.
- The provider had a system in place to monitor the quality of the service but this had not been effective. Audits of some aspects of the service had been undertaken. In some instances, shortfalls had been identified but there had been no follow-up to ensure actions had been taken. The provider's representative had carried out clinical governance audits at the home. These were lacking in detail and had failed to identify the shortfalls we found.
- There had been no effective oversight or analysis of incidents and accidents. This meant that measures to prevent recurrence had not been put in place. For example, four staff had been dismissed for sleeping on duty. The provider was unable to demonstrate that a root cause analysis had been undertaken so that any identified actions could reduce the risk of recurrence.
- The provider had not always ensured that staff had undertaken training at a level that fully equipped them with the knowledge, skills and confidence they needed to provide people with the support they required. The registered manager had only completed a few of the training sessions they expected staff to complete. They agreed they had no way to assess the quality and effectiveness of the training.
- External professionals working with the staff team had put an action plan in place. They reported that several months later the majority of the actions had not been completed. They were concerned, for example, that the nurses had been unable to improve the support plans.
- Action taken by the registered manager following a medicine administration error did not give us confidence that the error would not occur again. An audit of medicines undertaken by the local authority had identified a number of issues that the home's audit had not. The registered manager had failed to follow the provider's complaints policy.
- The provider had failed to recognise that the quality monitoring system needed further development so that identified actions could be taken to drive improvement.

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

- There was no evidence that the provider had encouraged people, their relatives and the public to express their views about the running of the home and the quality of the service being provided.
- Staff told us that they had staff meetings, but they felt their views were not always listened to.
- The registered manager had developed links with the parish council. Other than that people were not involved in the local community.

Failure to have effective governance systems in place has meant that the areas for improvement have not always been identified, nor has the action needed to make improvements been taken in a timely manner. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not always notified the Commission of incidents, as required by the regulations.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

- People had not always been supported in ways that achieved positive outcomes for them. For example, staff had failed to follow professional advice relating to one person, which had resulted in a deterioration of their health. Another person had left the service. Staff told us this might not have happened if they had been trained and supported to meet the person's needs.
- However, two people had progressed well since moving to Glebe Farm. They had settled in, were showing fewer signs of anxiety and had started to speak. One of their relatives said, "[Name's] doing really well – settled in quite surprisingly."
- Support workers felt supported by each other and most of them told us it was a really good staff team who supported each other well. One support worker told us, "We've a very supportive team – we've come together well." Another support worker said support workers and nurses worked very well together and respected each other. However, they added, "Management and office staff don't respect us at all."

Continuous learning and improving care

- The provider had not ensured that staff were suitably inducted, trained and supported before working with people.
- There had been little learning from accidents and incidents that had taken place
- Input from external professionals had not been fully taken on board and used to improve people's support.

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

- Relatives were satisfied that they had been told about incidents involving their family member. However, they had not received as much general communication from senior staff as they would have liked. They wanted to know about their family member's life at Glebe Farm, what they had been doing and things that had gone well.

Working in partnership with others

- The management team had held regular meetings with external health and social care professionals who

had concerns that the support being provided to people had not improved outcomes for people. One external professional told us, "Many meetings have requested changes in care, support and activity planning, however, there is little evidence that this has been implemented." However, not all recommendations from these meetings had been implemented, demonstrated by the incomplete actions on the action plan.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Commission of all incidents.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Support plans were not sufficiently person-centred or accurate for people to receive consistent support. There were no end of life care plans in place. Activities were not always provided in line with people's assessed needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always cared for safely. This was due to the lack of suitable and adequate staff; failure to follow correct safeguarding procedures; inadequate management of risk; and failing to learn from previous incidents.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to monitor the quality and safety of the service were not sufficiently robust to identify areas where quality and safety were being compromised.

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 sufficiently competent, skilled and experienced staff were deployed so that they could meet people's needs and keep them safe.