Achieve Together Limited

Inglewood House

Inspection report

56 Middle Gordon Road
Camberley
Surrey
GU15 2HT

Tel: 0127664776
Website: www.achievetogether.co.uk

Date of inspection visit:
04 April 2022
05 April 2022

Date of publication:
23 November 2022

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?	**Inadequate**
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
Inglewood House provides accommodation and personal care for up to 12 people who have a learning disability and autism. At the time of our inspection, there were 11 people living at the service. The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 12 people. This is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size.

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

Right Support:
The provider could not show how they met the principles of Right support, right care, right culture. This meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

Right Care:
The model of support did not promote maximum choice and independence. The ethos, attitudes and behaviours of managers and staff did not ensure that people lead confident inclusive and empowered lives.

Right culture:
The provider did not focus on people's quality of life, and care delivery was not person centred. Staff did not recognise how to promote people's rights, choice or independence.

People were not protected from abuse from staff. There were not sufficiently trained or supervised staff to safely meet the needs of people. Incidents of behaviours were not always recorded in sufficient detail to look for trends and themes. Staff were not always kind and respectful towards people.

People were not protected against risks associated with their care. Health care professional advice was not always being sought in relation to people's care. Staff were not following the principles of the Mental Capacity Act 2005. There was a lack of management and provider oversight to review shortfalls of care to make improvements.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. We received concerns prior to the inspection related to people not being protected from abuse and unsafe care being delivered to people.

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.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people not being protected from abuse, safe care and treatment and the lack of trained and appropriately supervised staff. We also identified breaches in relation to the staff not being caring and respectful, lack of meaningful activities, consent to care not being appropriately sought, complaints not being responded to and lack of robust management and provider oversight at this inspection.

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

Follow up

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.

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

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?

Inadequate

The service was not 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.

Inglewood House

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
Our inspection was completed by two inspectors over two days.

Service and service type
Inglewood House 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 meant they and the provider was legally responsible for how the service is run and for the quality and safety of the care provided. On the day of the inspection we were supported by members of the providers senior management team as the registered manager was absent from the service.

Notice of inspection
This inspection was unannounced

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke and communicated with four people who used the service. People who used the service who were unable to talk with us communicated using their body language and basic sign language. We spoke with eight members of staff including care staff and senior management.

We used the Short Observational Framework for Inspection (SOFI) spent time observing people. 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 five people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a further one care plan, training and supervision data and quality assurance records. A variety of records relating to the management of the service, including policies and procedures were reviewed. We also spoke with six relatives and two health and social care professionals.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- The provider had not protected people from abuse and neglect. Prior to the inspection we were made aware of incidents of abuse that had taken place at the service. Whilst the provider took immediate action as soon as they had been made aware, we identified further instances of verbal and emotional abuse by staff which could have been prevented.
- People we spoke with told us at times they did not feel comfortable or safe at the service. Comment included, "She [staff member] moans to the other staff about me and the others", "[Person] asks for lots of coffee and [staff member] gets cross and says no! no! no!, just like that. I'm not sure she should say that like that" and "If she [staff member] sees me in my room she shouts to me to come out, it upsets me. She says it in such an angry way. [Staff members] are quite angry. It can be scary."
- We made the management team aware of the concerns raised by people and they took action to address this straight away.
- Relatives told us they were not always happy with the way staff spoke with their loved ones. Comments included, "He [their family member] said they were very bossy and the [member of staff] was awful and the biggest bully" and "We thought some of the members of staff were really quite rude to people. I have found some staff talk to [family member] like that. They sometimes make fun of them."
- Although staff had received safeguarding training, they were not always recognising or reporting abuse. One member of staff told us, "I had to speak to the [senior on duty] as she [staff member] was shouting at service users." This was not reported to the local authority or investigated by the senior member of staff. We saw from the notes of a one to one supervision in June 2021 a member of staff raised concerns about verbal abuse from another member of staff to a person. This was not reported to the local authority or investigated by the senior in charge.
- We saw from an incident form a person displayed a behaviour. According to their care plan they displayed this behaviour when they were feeling anxious. Instead of staff following the strategies in place to support the person, they were asked to stay in their room and 'reflect on their behaviour.' The response to this by the member of staff was not picked up by other staff or the provider on review of the incident form.
- During a provider audit in February 2022 it had been identified that safeguarding contact details were not accessible for people. We found this had not been addressed. There was no information available to people on what they could do if they had concerns.

As the provider had not ensured people were protected from abuse and neglect this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risks to people were not were not always appropriately assessed or measures taken to enable people to live safely in their home. For example, one person's care plan stated the person was very nervous of shiny floors due to a previous trauma they experienced. Despite knowing this the provider removed the carpet and installed new vinyl flooring in the service. This impacted the person who staff told us was anxious to come of their room once the flooring had been fitted. No assessment of risk was undertaken to consider the impact on the person. After the inspection a health care professional told us, "This has set [the person] back a bit."

● Another person had a behaviour if they were anxious where they would hoard items in their room including cigarette butts the person may find on the ground. According to the person's care plan staff were to ensure they smoked offsite. We saw in the garden, that was accessible to people, there were cigarettes butts lying around. Staff had not taken appropriate steps to remove these from the garden to reduce the risk to the person.

● We found that one person's pressure mattress had not been set correctly based on their weight. According to their chart the person weighed 53.4 kilograms (kg) however their mattress setting was at 75kg. This meant the effectiveness of preventing pressure sores was reduced. There was also no skin integrity risk assessment in the person's care plan.

● One person was at risk of choking and we observed was being given thickener in their drink and food pureed. There was no choking risk assessment in place in relation to this or mention of thickener required. Their care plan stated, "At present she does not require any form of thickener in her drinks." This meant there was a risk staff who did not know the person may give the person drinks that had not been thickened.

● Risks associated with people's epilepsy were not always managed in a safe way which put them at risk. One person was known to have drop seizures and their care plan stated they should wear a protective head gear when in the kitchen. However, we saw the person being supported to make a drink in the kitchen and they were not wearing this.

● Another person with epilepsy had not had their risk assessment updated to reflect their changes in mobility. There was also no information for staff on how the person's seizures presented. This meant staff may not be aware of the signs to then provide the most appropriate care.

● Behaviours and incidents were not always recorded and analysed to look for trends. This meant there was little opportunity for lessons to be learned when things went wrong. Prior to the inspection we were made aware of incidents where one person had been physically aggressive towards other people. There was no record of this in the behaviour charts despite us being told by staff one person had recently been scratched by the person.

● Prior to the inspection a health care professional raised concerns with the local authority relating to a person that had unaccounted weight loss over a period of nine months. The health care professional confirmed the weight loss had started in May 2021. The person's nutritional risk assessment had not been reviewed by staff until the health care professional requested this in February 2022. The nutritional assessment identified the person was at high risk of malnutrition. Staff were only weighing the person monthly and despite frequent instances of weight loss no additional action was taken to address this.

The failure to not always manage risks associated with people's care in a safe way is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

● There was a risk that people would have anti-psychotic medicine when it was not always required. There were people that were prescribed 'as and when' medicine for particular behaviours. There was no guidance in place for staff on when this needed to be administered. We saw one person had been given this medicine on two consecutive days. There was no record of what strategies staff followed before this was administered

or why it was given.
● Another person had been administered anti-psychotic medicine for a number of years as prescribed. However there had been no steps taken by the staff at the service to determine whether this medicine was needed. This was despite a health care professional raising concerns about the person's health which they believed may have been as a result of receiving the medicine. They fed back that staff had reported the persons incidents of behaviours were very rare. They said when they asked staff why this medicine had not been reviewed a member of staff told them, "If it ain't broke don't fix it."
● There were areas of the management of medicines that were not safe. A member of staff showed us a stock of out of date medicines for a person. They were prescribed this medicine in the event of a seizure. There was a risk staff would administer the out of date medicine which may be less effective for the person.
● The recording of the stocks of medicines were not always clear on people's medicine administration record (MAR). A member of staff administering medicines on the inspection also shared with us that where stock amounts were shown on the MAR this did not always reflect the actual amounts in stock. This meant that is was not always clear for staff on whether they had sufficient medicines in stock for people.
● On each MAR there was a list of medicine that people were prescribed however this did not always match their prescriptions. It was not clear whether some medicines had been discontinued or whether there was a risk the person had not received all their prescription as required.

The failure to ensure the management of medicines was always undertaken in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● There were not always sufficient staff to manage people's needs safely. Prior to the inspection we were made aware of incidents of physical abuse that had taken place from one person to other people. These incidents started in December 2021 and were continuing up to the point of inspection. The provider told us they were ensuring a one to one member of staff was allocated to the person. However, we did not see the person in receipt of one to one support on the day of the inspection.
● The provider told us five staff were required to be on duty on the morning and afternoon shift to meet people's needs in a safe way. We noted from a staff rota for March 2022 there were four shifts where there were only two staff. On six occasions there were only three staff on a shift. A member of staff told us of managing staff levels, "We are in a staffing crisis at the moment."
● We asked the provider to confirm how they determined how many staff were required to meet people's needs. They told us they assessed this on the needs of people and what funding was being provided to people. However, despite requests they were unable to provide any evidence of how people were funded. This meant they could not be assured they assessed the correct staff levels. They had also not accounted for one person needing one to one staffing.
● The provider had not ensured that agency staff were provided with a summary of people's needs. Prior to the inspection the provider told us due to high level of agency use they were ensuring there was a summary of people's needs staff could read. However, this was not in place on the day of the inspection. An agency member of staff told us, "I have not been given a one-page profile or care plan to read yet. I am shadowing and hope to have time to read the care plans later." This meant there was a risk staff would not the most appropriate care to people.

The failure to ensure there were sufficient numbers of competent staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We asked the provider to send us evidence of checks they had undertaken for all agency staff working at the service. We noted that there were no profiles for three of the agency staff that according to the rotas had worked at the service. This meant they could not be assured appropriate background checks had taken place.
●The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

We recommend the provider ensures that all staff working at the service have appropriate background checks in place.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider was facilitating visits to people living at the home in accordance with current infection prevention and control guidance.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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; Supporting people to live healthier lives, access healthcare services and support

● People were not always being supported to access health care professionals support. Prior to the inspection the local authority made us aware of concerns. They stated a health care professional met with a person and had identified they had urinary incontinence for approximately 12 months. No staff at the service had taken steps to consult any health care professional advice in relation to this to determine the underlying cause.
● According to their care plan one person had difficulty in hearing and had hearing aids. The record stated they had lost them at some point but there was no evidence on what actions had been taken to replace the hearing aids. Staff told us the person's verbal communication had decreased however there was no record of when the person was last referred for a hearing test.
● We saw from their care plan one person had not had an optician appointment since 2018 and a dentist appointment since November 2020. The lack of appointments had also been identified on a provider audit in February 2022, yet no action had been taken to address this.
● We saw from a person's health care appointment records in July 2021 it was recommended from the health care professional a person was 'weaned' off medicine and for staff to monitor the person's response to this. However, there was no record of any monitoring of this by staff and we saw from the person's MAR they were still being given the medicine every day. This meant that input from appropriately trained specialists to ensure the person was leading a healthy quality of life was not being followed by staff.
● There were people who had lived at the service many years and whilst there had been an assessment of their needs and choices this was not reviewed regularly. Staff told us people were allocated a key worker. The key workers role was to meet with people once a month to review their care to ensure it met with their needs and preferences. However, we saw from the care plans these meetings were not taking place.

As risks associated with people's health needs were not always being met and care was not reviewed this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff were provided with training around the needs of people including autism awareness and positive behaviour support. However, the training was not always effective in ensuring staff were competent to provide appropriate care. We identified through incidents reports that staff were not always responding to

incidents of behaviour. One relative said of staff training, "They should have been trained better in how to speak to people with a learning disability."

● Supervisions were not effective in identifying poor practice at the service. A supervision should be an opportunity to monitor and reflect on practice; review and prioritise work with individuals; provide guidance and support and identify areas of work that need development. However, we found the registered manager was undertaking supervisions with the deputy manager remotely. They would not have had the opportunity to review the member of staff's performance at work.

● The service policy stated staff were required to have a one to one meeting with their manager every six to eight weeks. According to the supervision records five out of 14 staff had not had a meeting with their manager since November 2021.

● There were people at the service who had needs relating to autism, learning disabilities, epilepsy, mental health and diabetes. We saw from the agency staff training records provided five agency staff had not any training in these areas. They also had not received training in positive behaviour support. This meant the staff may not be equipped to provide the most appropriate care to people.

● There were people at the service that were required to have emergency medicine if they had a seizure. In one person's care plan it stated, "All staff who will support [person] will need to ensure they attend epilepsy training on seizure management." During the inspection a senior member of staff confirmed that night shifts were covered by agency staff who had not received this training. They told us in the event the person had a seizure they would need to call an ambulance. This meant there may be a delay in the person receiving appropriate medicine.

As the provider had failed to ensure that staff received appropriate training and supervision this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● People and relatives did not always feel that staff always asked for consent around care. One relative told us, "I heard them tell [family member] what they were doing, rather than ask."

● People's rights were not always protected because staff did not always act in accordance with the Mental Capacity Act. We saw that there were decision specific capacity assessments in place in relation to finances, consent to care and medicines. However, there was not always evidence of meetings where discussions took place with staff, family and health care professionals to ensure that whatever care was provided it was done in the person's best interest.

● There were people that had monitors in their room so staff at night could be alerted should they have a seizure. Although an assessment of their capacity had taken place there was no record of a discussion to

determine whether it was in the person's best interest. There was no record of whether alternative least restrictive measures had been considered.
● Another person's mobility had declined and was required to sit in a specialised wheelchair. However, we noted on both days of the inspection the person was placed in bed by staff. We did not see staff ask the person if they wanted to go to bed and there was no information in their care plan that this was required.
● The provider told us after the inspection that evidence of best interest meetings relating all restrictions including the monitors could not be located. This meant there was a risk that restrictions were being placed on people without following due process to determine if this was appropriate. We asked the provider to send us evidence of where DoLS applications had been submitted. These have not been received.

As care and treatment was not always provided with the consent of people and the principles of MCA were not being followed this is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We asked people if they liked the food at the service. One person told us, "We have the same menus, the same meals." We noted people were not involved in decisions about what they wanted for lunch on the first day of the inspection. One person told us, "They [staff] just decide."
● People were given a small roll with a sausage and were not offered seconds until we requested this. When staff offered a second portion people welcomed this.
● One member of staff told us, "I have never seen people being encouraged to help themselves to food. And yet, I cannot understand why staff are allowed to eat so much food; it's embarrassing to see how they pile their plates up at mealtimes, compared to the small portion they serve to the residents."
● People told us they were not allowed to help themselves to drinks when they wanted. One person said, "We can have a coffee in between meals but we have to ask permission first." A senior member of staff also raised concerns with us that people were not being encouraged, where appropriate, to help themselves to snacks and drinks when they wanted.
● On the second day of the inspection we found improvements. We saw staff cooked a more appetising meal and snacks were being offered in between meals. We saw people being offered drinks and encouraged to go into the kitchen to make drinks.

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

● The premises suited the needs of people living at the service. The home was tastefully decorated including furnishings and fittings.
● The rooms were lightly coloured, but the lighting was not overly bright so as not to overstimulate the people living with autism.
● People's rooms were personalised and individual. Where people had particular interests and hobbies this was evident from their bedrooms.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People fed back to us that staff were not always kind and caring and that they would often stay in their room where they felt calmer away from certain staff. Comments included, "I stay in my room more now, so I don't hear the shouting" and "I don't want to hear [staff member] shouting at people. She is always shouting."
● Relatives raised concerns with us about how at times staff spoke with their family members when they visited the service. One relative said, "I think [member of staff] spoke to some people dismissively." Another told us, "There was no respect. They [staff] almost used to take the mickey out of people, my [family member] included. It was horrible." A member of staff said, "She [staff member] was also rude to a staff member, calling him boy."
● On the first day of inspection we found staff were not always treating people with dignity and respect. When we arrived on day one a member of staff introduced us to a person who was still in their pyjamas. The member of staff said to us in front of the person and out loud in front of other people, "[Person] has declined personal care which is why she is still in her pyjamas." The comment was not necessary and not dignified for the person.
● On one occasion two staff were discussing a person within the person's earshot. We heard the person say, "That's not right, they shouldn't be talking about me." We raised this with the staff to make them aware this was not appropriate.
● During lunch a member of staff shouted to a person, "Go and sit down; go and sit down please. Sit down there." The member of staff then gave lunch to another person and said loudly, "What do you say?" The person said thank you and the member of staff responded in a patronising way, "Well done." One person reacted to staff speaking loudly to people and said, "Why do you keep shouting all the time?" One relative told us, "They [staff] didn't show people the respect they deserve."

As people were not always treated with dignity and respect this is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People and their relatives did not feel they were involved in decisions about care. One relative told us, "There have been occasions when she has told me that staff didn't listen to her.

● People told us they were not asked whether they wanted to do things rather they were told by staff which they said they did not like. One person said, "[Staff member] shouted at us, telling us when to do things. She told me that I must do things. I want to do things when I want to do them." A relative told us, "There is a definite difference in how some staff engage and support people, some [staff] are just disinterested."
● People told us they were not able to access the kitchen when they wanted. One person said, "If I'm on my own in the kitchen [staff member] might say, 'why are you alone in the kitchen?'". We spoke with a senior member of staff who said there was no reason people could not access the kitchen when they wanted.
● There were people at the service who had no relatives involved in their care. The provider had not taken steps to ensure they had an independent advocate to make sure their views and wishes were heard.
● People's wishes and aspirations were secondary to how the service was run. For example, before they went off duty staff woke one person early to ensure that they were ready for breakfast at 7am before the day staff came on duty. The person told us, "They come in and wake me up at 06.30. Sometimes you just want to lay there and sleep more."

As people's independence and involvement in their care was not considered this is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Once the provider had taken steps to address the concerns we raised on the first day, we found the atmosphere on day two had improved. We observed kind and caring interactions between staff and people and people appeared more relaxed.
● On both days we observed all of the management team were engaged with people and respectful towards them. When people came to the office they were welcomed in by the management and supported with their needs. There was laughter and jovialness between the people and the management team, and it was clear people were comfortable with them.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

● Although relatives accepted activities had reduced at the start of COVID-19 they fed back their concerns about lack of meaningful activities for people including going out since the restrictions relaxed. They told us this had negatively impacted their loved ones. Comments included, "They just completely stopped all activities and so that's all he does now is sit in his room. He thrives when he is sociable and involved with things so that has been really sad" and "They have fallen short with [family members] day to day activities and socialising and we have noticed a difference in their mood."
● On the day of the inspection there was no evidence of meaningful activities on offer specific to the needs of people. There were long periods of time where people had no meaningful engagement with staff. Although staff took five people out in the afternoon to bowling according to the people's daily notes this was not regular. One person told us, "When I have wanted to go out a few times [staff member] will say to me, 'Oh stay here today'. It makes me feel sad."
● For 40 minutes in the morning of the inspection we observed a person sitting on their own doing a puzzle. There was no interaction from staff at all. When a member of the management team spent time with them later in the morning, they noticed there were pieces of the puzzles missing. This meant the person would not have been able to complete the puzzle. We later heard a member of staff repeatedly say they needed to get new puzzles for the person.
● We asked staff what activities were planned for people and they told us, "They all have activity plans and today is a free day for everyone." This was not according to people's schedules for that day which included keep fit and disco.
● There was limited meaningful and person-centred activities offered to people. According to one person's daily diary, over 30 days they went out 12 times. This was limited to walks to a park, college and a drive with staff. According to another person's diary for the same time they went out on three occasions for a walk and was only offered to go out on another three occasions.
● A member of staff told us, "I think lockdown has affected activities. We need more fresh ideas about activities. For example, I suggested cake decoration and made a cake for this, but the carers did not do it and the cake was left in the oven overnight so had to be thrown out."
● The provider had not considered the guidance around right support, right care, right culture which advises social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.
● Care plans were not always detailed around people's life histories. One person's care plan stated they had

no contact with their family but there was no other information on their life history.
● Information in people's care plans was not always reflective of their most up to date needs or care required. One person's care plan stated their bedroom was on the first floor. However, they had moved to a different room in the house. The care plan stated the person could speak well however staff told us and we observed the person was now unable to verbally communicate. This meant staff may not provide the right level of care and in line with people's wishes and preferences.

Care and treatment was not provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints were not always recorded and responded to appropriately. People fed back to us they had made complaints to the registered manager about staff conduct. They told us they were thanked for providing this information, but they had no feedback from the registered manager on how this had been investigated.
● Relatives we spoke with told us complaints they raised were not addressed. Comments included, "I reported a concern to the [registered] manager but I don't think she did anything about it", "They didn't seem to take any action to the complaints we've made in the past", "We made a complaint. We thought it had been resolved. But obviously it hadn't been dealt with properly" and "No faith in that they are actually going to take proper action."
● We asked a member of the management team for the complaints folder, but they told us this could not be located. We saw from a staff supervision file that a relative had made a complaint however there was no record of how this had been responded to or investigated.

As complaints were not always recorded and responded to appropriately this is a breach of Regulation 16 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.

● Staff had not always considered people's individual needs to communicate with people in ways they understood. We did not observe staff using accessible ways to communicate with people during our visits.
● One person's communication plan stated they communicated using verbal cues and Makaton signing, as well as eye contact. It also stated they use a whiteboard. A member of staff told us, "No staff here are trained in Makaton" and "I have looked and cannot find the whiteboard, it seems to be lost." This meant there may be missed opportunities to communicate with the person in a more effective and meaningful way.
● Another person's care plan stated that pictures helped them with understanding communication. We did not see staff try and engage with the person with pictures.

End of life care and support

● The majority of the people at the service were younger adults and conversations were not needed to take place around end of life care.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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; Continuous learning and improving care;

- The registered manager had been working remotely from the service for a period of time since April 2020. This meant during this time there was no robust management oversight at the service.
- The registered manager and provider had failed to investigate concerns relating to people being abused at the service. This was despite evidence that indicated poor staff culture. Although this has now been addressed by them the failure to have robust oversight of the poor culture had a direct impact on the people living at Inglewood. A member of staff told us, "The oversight now is to hone in on the closed culture which I think exists here."
- People were not being supported to lead meaningful and empowered lives. There was a lack of management and provider oversight to ensure people had access to activities there important to them.
- Systems in place to monitor the delivery of care were not robust and this impacted on the care that people received. There had been an audit undertaken by a member of the provider's quality team in February 2022. Areas identified for improvement had not all been addressed. For example, it had been identified that 'as and when' guidance needed to be included for people on anti-psychotic medicines and people were not always accessing health care professional support. We found this had not been addressed.
- There were some shortfalls we identified that had not been picked up on the providers audit including risk assessments not being accurate around people's needs. The audit also did not identify that people were not accessing meaningful activities.
- The provider was not following their own policy in relation staff members working together that were family or living in the same household. The policy stated, 'where working at the same service cannot be avoided your manager will undertake a risk assessment and put in place measures to ensure that you avoid working together as much as is feasibly possible'. We found from rotas member of the same household working together. There was no risk assessment in place in relation to this.

The failure to ensure quality assurance and governance systems were effective service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The provider has taken steps to increase management oversight of the service including an interim manager being present at the home and frequent visits from senior management team to support the manager

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

● People were not involved in the running of the service and as such were unable to influence positive changes. There were no residents' meetings taking place to discuss activities, the menu and any other areas they wanted to talk through. One person told us, "We haven't had meetings. I would like to get together."
● Relatives told us they felt the service had deteriorated and the registered manager not being at the service had impacted on care for their loved ones. Comments included, "Since [registered manager's] absence it's gone downhill", "Nobody gives you straight answers anymore" and "Recently I don't think it's been a pleasant place to live."
● Staff told us they did not feel supported and were feeling the absence of the registered manager at the service. We saw from staff meeting minutes in January and February 2022 there was a standard agenda. There was an option to discuss safeguarding and whistleblowing however, this was not discussed on either occasion. This could have been an opportunity for staff to reflect on things they had observed in the home and report appropriately.
● Concerns raised on audits in 2021 that were received from relatives were not acted upon. We saw from one audit a relative stated they wanted more regular contact from the provider and an increase in activities for their loved one. They stated on the survey, 'We've been trying to get people to listen to us for over a year and nobody has taken any action'.

The failure to ensure performance was evaluated and improved was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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; Working in partnership with others

● Where incidents and accidents had occurred, we noted from the records that families were not contacted. There were frequent incidents of behaviours from one person to other people yet there was no record that relatives had been contacted on each occasion.
● There were not sufficient steps taken by the registered manager and the provider to ensure partner agencies were involved in people's care. One social care professional told us they had not been consulted in relation to building works taking place in the home that they knew would have impacted on the person's mental health.
● The local authorities who funded the care for people at the service told us they had not been made aware of the long-term absence of the registered manager at the service. They also told us they had not been made aware of the low staff levels at Inglewood.
● We saw from the provider audit in February 2022 it had been raised there was a lack of evidence of input from health care professionals. It stated health action plans had not been updated to include any visits people had with dentists, optician and hearing tests. We found the same concerns at this inspection.
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had not informed the CQC of significant events including incidents and safeguarding concerns.

The failure to ensure there was robust oversight of care, be open and transparent when things went wrong, and the service worked in partnership effectively with other agencies is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was provided that met people's needs.

The enforcement action we took:

We have imposed a condition to the providers registration.

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.

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers registration and we have cancelled the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring care and treatment was provided with the consent of people and the principles of MCA were followed.

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers registration and we have cancelled the managers registration.

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 not ensured that risks associated with people's care was managed in a safe way.

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers

registration and we have cancelled the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from abuse and neglect.

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers registration and we have cancelled the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure complaints were recorded and responded to appropriately.

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers registration and we have cancelled the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust oversight of the service and ensure quality assurance and governance systems were effective

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers registration and we have cancelled the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient suitably trained and supervised staff at the service to meet people's needs in a safe way.

The enforcement action we took:

We have imposed a condition to the providers registration and we have cancelled the managers registration and we have cancelled the managers registration.