Spectrum (Devon and Cornwall Autistic Community Trust)

Tanglewood

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
Tanglewood is a residential care home providing personal care for up to three people with learning disabilities. At the time of our inspection three people were using the service.

The service is a detached single story building with enclosed rear garden. The accommodation is sub divided into two, the main house where two people live and an adapted annex for the third person. It is located in a rural area near St Austell, Cornwall and people were unable to access the local community without support from staff.

People's experience of using this service and what we found
An analysis of rotas found that on nine occasion in the three weeks prior to our inspection staffing levels within the service had been unsafe. Staff recognised that people had been exposed to risk as a result of low staffing levels and told us, "The staffing honestly is a little bit scarce. We do have short periods of time where the overlap is not quite right" and "In my opinion it was not safe, it was horrendous. I managed, there was no incident, but you are just waiting for something to happen."
Relatives told us they felt staffing levels in combination with high staff turnover had exposed people to risk. They told us "There is no continuity. It is not the nice calm orderly place that it used to be".

Incidents had not been reviewed and analysed to identify patterns or trends. Unplanned restrictive practices were used during the inspection as staff had not followed guidance included in people's care plans.
All necessary staff pre-employment checks had been completed to ensure people's safety and staff understood local safeguarding procedures. Medicines were managed safely and there were systems in place to protect people from financial abuse.

All new staff received induction training and supervision had been provided. System to ensure training was regularly updated were not entirely effective and additional training updates were arranged following the inspection. The service was well maintained and action had been taken to address issues identified during our previous inspection.

There was limited evidence of best interest decision making available and there was a lack of evidence available to demonstrate the provider had acted on a recommendation issued by the commission in relation to restrictive practices following our last inspection.
People had limited choice and control of their lives. Tools developed to support people to make decisions were not being used by staff as they were concerned subsequent changes to plans as a result of staff availability my cause people additional anxiety. Staff were caring and responded promptly to people's needs.
People did not receive person centred care as care plans were not fully understood by staff and did not always reflect peoples current support needs. Staff had been provided with guidance on how to meet people's communication needs but this guidance had not been consistently followed.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support. Staffing levels and the availability of staff who were able to drive had limited people's ability to access the community. Tools designed to enable people to participate in decision making around activities were not being used as staff did not know if staff would be available to support people to engage with activities they had planned. Staff told us, "[We are] very short staffed, it's a very big issue with continuity and non-drivers. It restricts the guys from going out for activities. [Person's name] does not do anything" and "[People] are often stuck in the house. It is only at changeovers really that they get to go out or when we have three [staff] like today."
Relative's were concerned that the lack of access to the community and activities was impacting on people's behaviour. They told us, "We took [Persons name] out by ourselves because we were fed up of [our relative] being left in the service", and "[My relative] is not occupied and is not getting the attention [they] need. [Person's name] is becoming bored and frustrated and unfortunately this is showing in [their] behaviour."

Complaints received had not always been fully investigated and there was a lack of evidence to demonstrate what action had been taken to address issues identified as part of the complaints process.

There was a lack of consistent leadership in the service. The registered manager had moved to another of the provider's services prior to July 2019. No new registered manager had been appointed and no notification of the registered managers absence had been submitted to the commission. Relatives and staff reported there had been six different managers since the registered managers departure. A new deputy manager had recently been appointed but rotas showed low staffing levels had meant this manager had spent the majority of their time providing care.

The provider' quality assurance processes were ineffective. Audits had been completed but had not resulted in action being taken to ensure compliance with the requirement of the regulations. Relatives told us they had lost confidence in the provider and were seeking alternative care placements. Their comments included, "It is not a very good picture really. It is just rather depressing thinking of the situation [My relative] is in."

Managers accepted that the service was not meeting people's needs and following feedback at the end of the inspection the provider has begun taking action to improve the service's performance. Additional resources had been made available and an action plan developed to drive improvement in the service's performance.

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

Rating at the last inspection
The last rating for this service was good overall but requires improvement for effective. (Report published 23 December 2017)

Why we inspected
The inspection was prompted in part due to concerns received in relation to staffing levels and the quality of support people were receiving. A decision was made to bring forward this inspection to examine those risks.

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

Follow up
We will request an action plan for 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

Tanglewood

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector.

Service and service type
Tanglewood is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 is required to have 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. At the time of our inspection there was no registered manager in the service. A deputy manager had recently been appointed to lead 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 and sought feedback on its current performance from the local authority. 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

We met with the three people who used the service. We also spoke with four members of care staff, the new deputy manager and the provider's regional manager.

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

After the inspection
Following the inspection, we spoke with the relatives of each of the three people the service supported. We also reviewed the information we had requested from the service during the inspection.

Requires Improvement

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.

Staffing and recruitment

- The service's business continuity plan identified that in "In extreme emergency situations" the emergency minimum staffing level for Tanglewood would be two, this would be shared support for two service users and one member of staff for the service user who lived in a separate annex.
- The service rota was designed to achieve this minimum staffing level with short periods each day where an additional staff member was available to support people to access the community. We compared the information available in the service's rota with staff sign in records. We identified nine occasions in the three weeks prior to the inspection where there had only been one staff member available to support the three people living in the service.
- Staff recognised there had been occasions where staffing had dropped below contingency levels and that this impacted on people's safety. They told us, "The staffing honestly is a little bit scarce. We do have short periods of time where the overlap is not quite right", "I have been the only person in the house but only for short periods of time" and "[Staff member's name] was on [their] own yesterday for an hour as well before I got in". One staff member provided a detailed description of the impact on safety of only one staff member being present in the service. They told us, "In my opinion it was not safe, it was horrendous. I managed, there was no incident but you are just waiting for something to happen."
- The provider operated an on-call system that enabled staff to report dangerously low staffing levels. Records showed staff from other Spectrum services had been moved to work at Tanglewood when possible. Managers recognised that current staffing levels were challenging and told us, "It is not unusual for one member of staff to be here on their own."
- Relatives were also concerned by the impact of low staffing levels and high staff turnover on people's safety. They told us, "There is no continuity. It is not the nice calm orderly place that it used to be", "We know they have been recruiting staff recently and it is this constant churning of staff that is worrying for us" and "I don't think they had enough staff they have had one member of staff doing a long shift, the overnight and then the following day."
- Records also showed that low staffing levels had impacted on people's ability to access the community and engage with activities they enjoyed. Staff recognised this had impacted on people well-being and had led to increased levels of frustration for people using the service. One staff member told us, "[Person's name] no longer gets much 1:1 support and that has led to more incidents and the turnover of staff also has increased the number of incidents."

The providers failure to ensure enough staff were available to safely meet people's care needs was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A recruitment campaign was underway to improve staffing levels within the service. The recently

appointed regional manager responsible for overseeing Tanglewood's performance told us, "We are trying to interview and get staff in but it seems like it has been a bit of a struggle."

Systems and processes to safeguard people from the risk of abuse
● Information about local safeguarding procedures was readily available and staff understood their roles and responsibilities in relation to ensuring people's safety.
● Staff would initially report safety concerns to the deputy manager but understood how to raise issues outside the service should this become necessary.

Assessing risk, safety monitoring and management
● People's care plans included risk assessments and staff had access to information detailing how they should act to ensure people were protected from known risks. This included information on how to support people to participate in a variety of sporting and outdoor activities.
● Staff said they did not use physical restraint techniques in the service and records showed training had been provided in Positive Behaviour Management (PBM) techniques. One staff member told us, "I have done PBM training. Not had to use restraint here, just defensive blocks really."
● On the day of our inspection we observed staff using a door holding technique to prevent one person's accessing the service's main kitchen. We reviewed this person's care plan and found this technique was not approved for use. The care plan indicated that the door should have been locked during the day, and if people wished to move between the main house and the annex they should do so using external doors. Staff had not followed this care plan which had resulted in the use of an unplanned restraint technique during the inspection. This issue is discussed further in the responsive section of the report.
● Incident reports had been completed and made available to the provider's leadership team via the digital care planning system.
● Firefighting equipment had been regularly serviced and there were Personal Emergency Evacuation Plans in place detailing the support each person would require in the event of a fire or emergency evacuation.

Learning lessons when things go wrong
● Audits of accident and incidents within the service had been completed up until October 2019. These audits were designed to help managers identify any patterns, changes or trends in people behaviours.
● Since November 2019 these audits had not been completed. This meant reviews and analysis had not been completed to identify patterns and trends in people's behaviour. This unnecessarily exposed people to risk. Staff told us one person's behaviour had recently changed significantly however, it was not possible to confirm this from the information available during the inspection process.

This failure to review and learn from incidents that occurred forms part of the breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and is discussed further in the well led section of the report.

Using medicines safely
● Medicines were administered safely, and Medicine Administration Records had been appropriately completed. Staff reviewed and audited these records at each change of shift to ensure people had received their medicines.
● There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security.

Preventing and controlling infection

- The service was clean and there were systems in place to manage infection control risks.
- Staff encouraged people to participate in cleaning and domestic tasks within the service.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

● At our last inspection we recommended, "The service seeks advice and guidance from the Supervisory Body to ensure potentially restrictive practices are in line with the legislation and subject to regular review". This recommendation related to the use of a 'reward' scheme used to encourage positive behaviour and the use of audio monitoring equipment at night to enable staff to respond if a person experienced a seizure.
● At this inspection we found limited evidence to demonstrate the provider had taken action or reviewed practices as a result of the recommendation.
● 'Reward' schemes were in place for two of the people who used the service. There were no records of best interest decisions or reviews of these schemes following our last inspection.
● Staff and managers did not fully understand these 'reward' schemes and the associated guidelines were not being followed. For example, one person was supposed to receive a certificate each time they received 30 tokens for displaying positive behaviours. At the time of our inspection this person had received over 60 tokens but no certificates had been produced.
● In relation to the other person's 'reward' scheme, when they had recently received a 'treat' as part of this scheme. This had also been provided to another person as there had not been enough staff available to enable the person individually to enjoy their 'treat'.
● Audio monitoring remained in place following the previous recommendation. There was no evidence to show the need for this monitoring had been reviewed since the last inspection to ensure it remained the least restrictive option.

The providers failure to act on the previous recommendation forms part of the breach regulation 17 detailed further in the well led section of this report.

● There were limited records available of best interest decision making processes. Where decisions had been recorded, they were not about specific decisions and were instead of a generalised nature.
● Some people who lacked capacity had restrictive care plans in place and were the subjects of continuous monitoring and control. Necessary applications to the local authority had been made for the authorisation of these arrangements under the Deprivation of Liberty Safeguards.

Staff support: induction, training, skills and experience
● New staff completed a two-week package of formal training before they began working in the service. Staff told us this training was useful and informative. Their comments included," Training was fantastic I loved it. It was the most in depth training I have had. Explaining methods of communication and the reasons behind things", "I think the training here is quite good" and "The training is fine, you do two weeks when you first start."
● The most recently appointed member of staff had not completed any shadowing or supernumerary shifts before being included on the service's rota. This meant they had minimal time to build and develop a rapport with individuals before having to meet their support needs independently.
● The service did not have systems in place to ensure staff training was regularly refreshed and updated. During the inspection process managers identified that staff needed training updates in topics including Positive Behavioural Support and Epilepsy Awareness. This training was subsequently arranged to ensure staff had the skills necessary to meet people needs.
● Staff told us they had received supervision and records showed that the new deputy manager had completed a number of staff supervisions. Staff comments included, "Supervision, I had my last one with [previous deputy manager] last month."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service had systems in place to ensure people needs were identified and understood before they moved into the service. This meant the service could meet the person's needs and expectations.
● Care plans were developed using information gathered during the assessment process and combined with details from the person, their relatives, involved professionals and previous care providers.

Supporting people to eat and drink enough to maintain a balanced diet
● A pictorial menu was used to enable people to choose the service meals and staff told us, "Each person chooses two meals during the week."
● People were supported to shop for ingredients, participate in meal preparation and to do the dishes and tidy up following each meal. On the day of our inspection one person enjoyed taking on responsibility of these tasks and chores.

Adapting service, design, decoration to meet people's needs
● The service was well maintained. Following a recommendation made in the 2017 inspection report some identified issues had been addressed and resolved.
●People's bedrooms had been individually decorated in accordance with their personal tastes and preferences.
● The service's garden area was not well maintained and was in need of tidying up.

Supporting people to live healthier lives, access healthcare services and support
● People had been supported to access healthcare services when required. However, there was limited

information available to demonstrate people had been supported to access annual health and wellbeing checks.

Requires Improvement

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 deteriorated to requires improvement. This meant people were not consistently involved as partners in their care.

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

- Staffing levels and the availability of drivers meant people were not able to engage with activities outside the service when they wished. As a result staff had taken action to limit people's ability to take part in decisions about how their support was provided.
- One person's care plan included details of a tool staff should use each evening to enable this person to participate in planning activities and to help manage their anxiety. We checked this tool as part of the inspection processes and found it had not been used as intended. When asked, staff explained the tool had not been used the previous evening as staff did not know what support would be available to enable the person to access the community. They had decided not to use the tool to avoid causing the person additional anxiety.
- During the inspection this person repeatedly asked staff for information on what activities were planned for the day. During the morning we observed staff using distraction techniques appropriately to help this person manage the anxiety this lack of information caused. This person told us, "I would like to go somewhere later" and was subsequently supported to go shopping later in the day.
- Relatives were concerned people were not always supported to make appropriate decisions and told us, "I don't really know if [my relative] gets to make choices." Other relatives were concerned people had not been appropriately supported when people made decisions that were contrary to their wellbeing. Examples were provided of people leaving the service without suitable clothing during periods of cold weather and not being supported to maintain their personal appearance.

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

- Staff responded to people's needs in a timely manner and provided encouragement, reassurance and support when required. Staff told us, "[Person's name] is so sweet" and spoke warmly of the people they cared for.
- Staff were committed to their roles. Rotas showed staff had completed additional shifts and extended shifts, overnight where necessary, to ensure people's safety.
- People had been encouraged and supported to take on responsibility of specific tasks within the service and took pride in completing these chores.
- Staff had completed equality training and peoples' diversity was valued and respected. However, relative's reported that people had not always been supported to participate in events that were culturally significant to them.

Respecting and promoting people's privacy, dignity and independence

● Staff supported and encouraged people to respect each other's privacy. People were able to choose to spend time on their own if they wished and staff acted to ensure support was provided with dignity.
● One person's relative was concerned low staffing levels had impacted on the level of help and support people received to manage their appearance. They felt this may have impacted on the person's wellbeing and told us, "[Staff] used to take much more care about that and they used to take much more care about [the person's] appearance. I think it might be down to a lack of staff available to supervise and support [my relative]."
● People were encouraged to do things for themselves and one person had taken on responsibility for a variety of domestic tasks within the service. It was clear this person enjoyed these tasks and valued the independence and skills they had developed.
● Care records and other confidential information were stored securely when not in use.

Requires Improvement

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 requires improvement. This meant people's needs were not always met.

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

- People's care plans were not up to date and did not always accurately reflect their current needs or the support being provided by staff.
- Relatives had been involved in the development and review of people's care plans and told us, "They did review [the care plan] in the autumn, I have seen it. It was quite long about 40 pages. It does give a good picture of [my relative]. I asked was there an abbreviated version but there was not one."
- On the day of our inspection it was clear that staff did not fully understand people's care plans and techniques developed to support people's individual needs were not being followed. For example, as detailed in the safe section on this report an unplanned door hold was used as staff had failed to secure a door to the kitchen in accordance with people's care plans. Staff told us, "All of [the care plans] need updating" and "I think the care plans could be shorter and easier to read for new staff."
- One person's care plan identified that their allocated staff member should wear a badge to help the person recognise who their staff member was each day. This plan had been developed to help the person manage their anxiety. This badge was not in use during the inspection and most staff were unaware of where it was. When staff later found the badge, its use was not reintroduced during the inspection. Staff told us, "[Person's name] care plan is just paper work. [The person] does need that visual reminder that I am [their] staff. We all need to stick to it but have not been."

- Care plans included identified goals people would like to achieve. Records showed this section of the care plan had not been regularly updated. In one person's file this information had not been reviewed since April 2018 despite significant changes to the person's routines which had resulted in them spending significantly more time in the service each week.
- People's care plans did include information about how to support people to manage their oral hygiene. However, relatives reported this support was not consistently provided and told us, "We have to go and check things like does [the] toothbrush head need changing, we have supplied them but they do not seem capable of monitoring it."

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.

- People's care plans included detailed guidance and information for staff on communication aids and

techniques that people had previously used successfully. This guidance was not fully understood and was not being followed during our inspection. One person's relatives reported that consistent and regular support was necessary to maintain their relatives' skills in using communication aids they were concerned this support had not been recently provided.

● Another person's care plan included detailed guidance on the use of a tablet computer to support them to communicate effectively. Staff did not use this equipment to communicate during the inspection. Relatives reported that consistent and regular support was necessary to maintain their relatives' skills in using communication aids. They were concerned this support had not been recently provided.

● Records in the staff communication book had been used to highlight communication successes one staff member had achieved by following guidance from people's care plans. They had suggested to other staff they try reintroducing the use of communication tools and other aids to help people manage their anxiety.

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

● The service was relatively geographically isolated and in a rural location. There were two vehicles allocated to the service but people's access to the community was limited by the availability of suitable staffing numbers and access to drivers. This meant the service was not operating in accordance with the principles of registering the right support.

● Staff recognised that staffing levels and access to drivers had meant they were unable to support people to regularly access the community and participate in activities outside the service. They were concerned this had resulted in increased levels of anxiety and behaviours that challenged others within the home.

● Staff told us, "[We are] very short staffed, it's a very big issue with continuity and non-drivers. It restricts the guys from going out for activities. [Person's name] does not do anything", "[Person's name] is bored, I would be" and "[People] are often stuck in the house. It is only at changeovers really that they get to go out or when we have three [staff] like today."

● Relatives told us there were concerned people had not been supported to access the community and were regularly spending most of their time within the service. They felt this was negatively impacting on people's well-being and had caused changes in people's behaviour. Their comments included, "We took [Persons name] out by ourselves because we were fed up of [our relative] being left in the service", "[My relative] should be getting 5 hours 1:1 a day but they have not been keeping up with that" and "[My relative] is not occupied and is not getting the attention [they] need. [Person's name] is becoming bored and frustrated and unfortunately this is showing in [their] behaviour."

● One staff member effectively summarised their concerns in relation to the adverse impact of staffing levels on people living at Tanglewood, they told us, "I would not say people are having a good life because of staffing. They are not able to go out, it is not easy to go out for a walk."

● Activity plans were in place to help staff identify activities people would enjoy. These records had not been updated since 2018 and did not reflect people's current needs and preferences. Relative told us, "We have to closely monitor the quality of care particularly in relation to opportunities to get out and engage with activities. If not occupied [person's name] gets very frustrated if not kept active" and [My relative] is not doing very much at all and is not doing half the things [they] used to. I think it is about drivers and staffing."

The evidence above demonstrated the provider had failed to ensure people received person-centred care. Care plan's were not fully understood by staff and did not accurately reflect people's current needs. Guidance in relation to people communication needs was not being consistently followed. People were not being enabled and supported to access the community when they wished and to live normal lives. These failures meant the service was in breach of the requirements of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There was a complaints system in place and polices detailing how the provider would respond to complaints received.

●These policies were not always constantly complied with and relatives told us concerns and complaints they made were not always resolved. Relative comments included, "We seem to be in a cycle where we raise concerns, things improve for a while, then things go wrong again and we have to complain" and "I've not really had a reply or an apology following the complaint, we did have a meeting but nothing really seemed to be taken on board."

● Records showed a formal complaint had been received in January 2020 which had led to a meeting between the person's relative, social worker and the provider's area manager. No minutes of this meeting were available and there were no records to show what action or changes had been made within the service or by the provider to address and resolve the issues identified.

The Providers failure to respond appropriate to complaints received meant they were in breach of the requirements of regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Managers and staff being clear about their roles

- The Provider is required to ensure there is a manager registered with the Care Quality Commission who is in day to day control of the service.
- There had been a lack of consistent leadership at Tanglewood prior to our inspection. The service's registered manager had been moved to another of the provider's locations before July 2019. No notification of the registered manager's absence had been submitted to CQC. No appropriate and effective arrangements had been made to provide leadership to the staff team since the registered manager's departure.
- Since the departure of the previous registered manager there had been numerous changes of leadership within the service. Relatives told us, "Managers have tended to be young and have not lasted very long", "I think there has been a lot of turn-over of staff and six different managers in 12 months" and "The managers are not being supported by the company as when they ask for staff they don't get them."
- Staff recognised that the lack of consistent leadership had impacted on the service's performance. Roles and responsibilities of staff in relation to specific tasks were not clearly defined and staff told us, "Since I have been here (less than 18 months) there have been six managers", "There has been a lot of change" and "The paperwork has fallen behind. They are trying to get on top of it". One staff member provided an summary of the situation and told us, "[A manager from another service] was overseeing it, it has been kind of running itself. It is very confusing for staff as we have not had anyone to ask for guidance."
- At the time of our inspection the service was being led by a, recently appointed, deputy manager who had started working in the service two weeks prior to our inspection. The deputy manager did not intend to become registered and was supported during the inspection process by the provider's recently appointed regional manager. Both managers recognised and accepted the service had not received the dedicated leadership it required.
- Staffing rotas showed that since the deputy manager's appointment to the service the time available to them to focus on leadership responsibilities was extremely limited. Low staffing levels meant they had routinely been providing care and support. Staff and the deputy manager were unaware of what arrangements the provider had made to identify and recruit a new registered manager for the service.

The failure to have a registered manager based in the service was contrary to the providers registration conditions. This meant the provider was in breach of regulation 5 of The Care Quality Commission (Registration) Regulations 2009. In addition, the provider had failed to notify the commission of the registered manager's absence from the service for a period of more the 28 days. This is a breach of regulation 14 of The Care Quality Commission (Registration) Regulations 2009.

● Staff were complimentary of the new deputy manager's approach and support they had recently received from the new regional manager. They told us, "[The deputy manager] and [Regional manager] are really nice."

Continuous learning and improving care, understanding quality performance, risks and regulatory requirements

● The provider had failed to effectively monitor the service's performance and ensure that high quality care was provided. Regional managers had completed audits which had identified significant issues with the service's performance prior to this inspection. However, limited action had been taken to address and resolve these quality issues. The breaches of regulations identified in the safe and responsive sections of this report had not been identified and prompt action had not been taken to ensure the service met people's known needs.

● As detailed in the effective section of the report the provider had failed to act on recommendations from the commission issued following the last inspection. This meant opportunities to review care practices and possibly reduce the level of restrictions present in the service had been missed.

● Relatives told us they had lost confidence in the provider's ability to meet their relatives needs and some reported they were actively looking into alternate care placements. Relatives comments included, "I said I had no confidence they would be able to change, it was as if they had not taken on board that I had asked for [My relative] to move", "It is not a very good picture really. It is just rather depressing thinking of the situation [My relative] is in" and "I would say in the last year it has not been very good and in the last six months it has been pretty poor."

● Staff recognised that the service was failing people and told us, "I would not want this for my relative."

● Managers recognised that staffing levels and a lack of consistent leadership had impacted on the service's performance. Their comments included, "There is a lack of consistent management and guidance for staff. I do not know what they did before I was involved" and "Stuff isn't being done for [Person's name], staffing is an issue."

● Low staffing levels had both exposed people unnecessarily to a risk of harm and prevented people from living normal lives. The service's relatively remote location in combination with limited availability of staff able to drive had limited people's access to the community and activities they enjoyed.

● People's care plans were not up to date or fully understood by staff. This meant people did not receive person-centred care.

Systems in place to monitor and drive improvement in performance were ineffective at the time of our inspection. This meant the service is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback at the end of the inspection site visit the provider completed an additional review of the service's performance and identified similar concerns to those detailed in the report. As a result of these findings an action plan was developed and significant additional resources provided to improve the service's performance.

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

● The providers regional manager and staff team within the service took an open approach to the inspection process. They recognised that the service was not always meeting people's individual needs and had not been open and honest about these issues during their dealings with people's relatives.

● Where incident and accidents had occurred details and relevant information had been shared with people's relatives. Meetings had been arranged between staff, senior managers and relatives to discuss

incidents and identified changes in behaviour. However, it was unclear what action or changes had been introduced following these meetings to improve the service's performance.

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

● Surveys of relative's views on the service's performance had not been completed since October 2018 and there was limited evidence available to demonstrate people's views on performance had been sought. Relatives told us, "Communication with the staff is not as good as it was."

● Equality and diversity issues were well understood and staff acted to ensure people were protected from all forms of discrimination.

Working in partnership with others

● At the time of our inspection there was an ongoing disagreement between the provider and care commissioners. This had arisen as a result of issues around the amount of support commissioned each day and processes for identifying and reviewing people's support needs. As a result of this disagreement relations between both parties had become strained.

● The commission recognises the positions taken by both parties in this dispute. However, it is of paramount importance that both parties work together to ensure people's support needs are met.

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 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider had not ensured that the service was led by a manager registered with the care quality commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 Registration Regulations 2009 Notifications – notices of absence The provider had failed to notify the commission of the registered manager's absence from the service for a period of more the 28 days. This is a breach of regulation 14 of The Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care. care plans were not fully understood by staff and guidance available in relation to people's communication needs was not being consistently followed. People were not being supported to live normal lives and engage with activities they enjoyed.. These failures meant the provider was in breach of the requirements of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not appropriately responded to complaints received. This failure meant the provider was in breach of the requirements of regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service quality assurance systems were ineffective and the provider had failed to act on previous recommendations. This meant the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staffing levels identified as necessary to ensure people's safety were consistently achieved. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.