Flarepath Limited

Cranmore

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

People's experience of using this service and what we found
People told us that they had been hit, and their hair pulled by a person living at the service, and that staff took no to very little action to prevent it. Staff we spoke with lacked the understanding that people would be upset and hurt by this, and failed to report it as abuse. Numerous incidents between people had been logged inconsistently and not reported to the local authority safeguarding team.

Incidents were not consistency logged and there was no oversight or management of incidents. As a result incidents re-occurred and people were harmed. Care plans and risk assessments were not updated following incidents and there was no mitigation put in place to avoid the incident re-occurring.

The culture of the service was poor. Staff spoke about and to people in a derogatory way; for example, calling them 'silly' and saying people 'threw paddies'. People had been 'told to go to their rooms' during incidents. People were not supported in a person-centred way in line with positive behaviour support. People's rights and dignity were not upheld.

People were unlawfully physically restrained by staff who had been trained but their competency not assessed to ensure they were using the correct techniques. The staff who trained the team on how to restrain people had not had recent training. The methods of restraint used described to us could cause people pain.

Staff lacked the skills, knowledge and guidance to support people. Staff were not trained in positive behaviour support, and punitive practices such as not allowing people to get magazines due to behaviours were used.

There was a lack of infection control measures placing people at significant risk from covid-19. Days before our inspection, staff started to wear face masks and told us they had not previously due to people's distress with PPE (personal protective equipment). People were observed not to be distressed by the PPE worn, and when we asked staff about this, they told us people could struggle to hear when staff used PPE. The service had a covid-19 outbreak in December 2020 and every person tested positive for covid-19.

There was no oversight or governance in place. The registered manager and provider failed to complete any audits of the service and failed to identify the significant concerns we identified during our inspection. The registered manager and provider failed to meet their regulatory requirement to notify us of safeguarding incidents.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People had unnecessary restrictions placed on them, such as not having access to toilet paper and being locked out of the kitchen. Staff lacked the knowledge and skill to support people in a person-centred way and lacked understanding on learning disabilities including autism and how people may present themselves. This had a negative impact on people's lives and infringed on their human rights.

Right support:
• Model of care and setting did not maximise people's choice, control and independence
Right care:
• Care was not person-centred and did not promotes people's dignity, privacy and human rights
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives

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

Rating at last inspection
The last rating for this service was Good (published 15 November 2017.)

Why we inspected
We received concerns in relation to the management of behaviours, the competency of staff and the risk management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We received concerns relating to mental capacity, and the environment, and therefore we inspected this part of effective only.
We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cranmore on our website at www.cqc.org.uk.

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 dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance, staffing and notification of other events 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 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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not Safe.

Is the service effective?

Inspected but not rated

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

Is the service well-led?

Inadequate

The service was not Well-led.

Cranmore

Detailed findings

Background to this inspection

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

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
The inspection was carried out by two inspectors.

Service and service type
Cranmore is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We did not ask the provider to complete a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with four members of staff including the, registered manager who is also the nominated individual; the nominated individual is responsible for supervising the management of the service on behalf of the provider, deputy manager, and two care workers.

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

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

● People were not safeguarded from the risk of harm and had been harmed. Incidents between people were not reported to the Local Authority Safeguarding team or to the Care Quality Commission. For example, when one person 'grabbed another by their face and neck' this was not reported. One person 'stabbed another in the head with plastic cutlery causing a puncture wound,' this was not reported. When people made allegations about staff bullying them this was not reported, nor action taken to investigate.

● People told us that one person at the service often hit them, and incident forms received confirmed this., One person told us, "[Person] constantly pulls my hair and it hurts. They hit me in the back, and they do it hard. Some staff say it doesn't hurt and I say, how do you know, because they do it hard." These incidents had not been reported to the local authority safeguarding team or identified as safeguarding incidents by staff and the registered manager.

● People had been unlawfully restrained. Following incidents of restraint there was no evidence that welfare checks had been completed on people. Staff and the registered manager failed to identify the potential abuse in unlawfully restraining people.

● The registered manager was unclear about the number of restraints that had occurred or the frequency. We asked one staff member when the last incident of restraint occurred and were told it was a 'long time ago.' The staff then advised us they had been involved in a restraint one to two months previous which was not documented. The registered manager had no oversight of incidents of restraint within the service.

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

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

● The registered manager confirmed there was no analysis of incidents to look for trends and patterns. An incident report reviewed from January 2020 detailed someone had hit another person in the back with their fist causing the person to 'scream in pain.' No action had been taken to reduce the risk of this re-occurring. There was no review of care plans or risk assessments and the person told us it occurred frequently, including on the day of inspection.

● Incidents had not all been documented on incident forms. One person's daily logbook detailed that they 'had gone into other people's rooms who claimed they had punched them in the face.' We discussed this with the deputy manager who confirmed they were unaware of the incident. There had been no investigation, review or mitigation put in place to ensure people were protected from the risk of the incident reoccurring.

● Risks to people had not been mitigated. People living with diabetes did not have their blood sugar levels regularly checked. Some people were at risk of constipation; there was no care plan or risk assessment in

place to guide staff on how best to support people. Some people had epilepsy; care plans and risk assessments were not clear on what their seizures looked like, or what action to take should the person have a seizure.

● Staff lacked the understanding, skills and knowledge to support people with learning disabilities and complex needs. When incidents occurred the registered manager and staff failed to put risk assessments in place and review behaviour support plans. Some people could display behaviours that could be challenging to others. When these incidents occurred, there was a lack of up to date guidance for staff to follow.

● Some people had behaviour management plans which suggested restraint could be used in line with the restraint policy. This was not available for staff in care plans, and the registered manager informed us that this was to ensure staff who were not trained in restraint could did not access them. However, this restricted all staff accessing the policy. The policy did not set out what type of restraint could be used on each person and lacked detail on how to perform the restraint safely, placing people at risk of harm.

● Risks to the environment had not been assessed or mitigated. The garden was littered with dangerous objects; broken chairs and uneven surfaces. Some people's risk assessments detailed that garden tools should be locked away when not in use. We found this was not the case.

● The registered manager failed to act on environmental risks; two fire extinguishers were not attached to the wall posing a risk to people.

Preventing and controlling infection

● Risks in relation to the spread of covid-19 had not been addressed. On arrival staff did not take our temperatures or ask if we had any symptoms of covid-19.

● Staff confirmed that they had not been wearing personal protective equipment (PPE) until days before our visit. Staff were still not complying with current government guidance in relation to covid-19 and the use of PPE whilst supporting people with personal care.

● There were no donning and doffing stations for staff to change their PPE. Staff confirmed they placed all used PPE in the kitchen bin. Government guidance states that contaminated waste should be stored separately and not disposed in general waste.

● The registered manager confirmed staff were working between sites which is against government guidance to reduce the spread of covid-19.

● The service was dirty and the registered manager confirmed it had not been regularly deep cleaned during the pandemic. Bathrooms were visibly dirty, walls were visibly dirty and one person did not have any pillow cases, revealing stained dirty pillows.

We have also signposted the provider to resources to develop their approach.

Using medicines safely

● Some people had 'as and when' medicines in place for example paracetamol. There was no guidance in place for staff to follow to ensure they did not administer more than the recommended dose in 24 hours.

● One person was prescribed nutritional supplements to reduce the risk of malnutrition. However, they had not received these for a period of 12 days prior to our inspection. The deputy manager informed us there had been an issue with the prescription, but sufficient action had not been taken to ensure the person received their prescribed nutritional supplements.

● The registered manager confirmed they had not completed any audits to ensure people had received their medicines as prescribed. Staff competency checks to administer medicines had not been completed by the registered manager or provider.

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

(Regulated Activities) Regulations 2014.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The registered manager confirmed that visitors had not been unnecessarily restricted.

Staffing and recruitment

● Staff lacked the skill, knowledge and competency to support people. Staff lacked knowledge in positive behaviour support (PBS) and triggered incidents. PBS is a person-centred approach to supporting people with a learning disability. For example, one staff woke people who were sleeping in the car by saying 'Boo, wake up.' This led to a person becoming distressed, shouting and telling staff they were bullying them. Incident forms evidenced staff did not de-escalate situations or support people in a positive way. For example, one incident when a person wanted to know when pancake day was, resulted in them being restrained on the floor, as staff refused to share this information with them.

● Staff received training for delivering training in physical intervention to others. The training course was completed in 2015 and there was no evidence of refresher training taking place to ensure they remained qualified to deliver the physical intervention training course. The course being delivered to staff was not in line with current best practice guidelines. There were no competency assessments completed on staff to confirm they were competent to restrain people safely. The deputy manager described a technique used which could inflict pain on people. The staff trained to deliver the physical intervention training had since left the organisation, and we could not be assured that staff were competent in psychical intervention.

● There was not sufficient numbers of suitably qualified staff to meet people's needs and keep them safe. The registered manager did not use a recognised dependency tool to assess people's needs and calculate the support they needed. The registered manager informed us staffing levels during the day were four to five care staff, depending on activities taking place. During the night the registered manager informed us there were three staff on duty who supported people at the service, and the providers other service situated next door. However, rotas showed that there were not always three staff working at night.

● The registered manager informed us they and one deputy manager had to work shifts, due to staffing vacancies. This had an impact on completing any quality improvement work and fulfilling their role as a registered manager. Whilst they were actively recruiting new staff members, this had a direct impact on people at the service, and the quality of care they received.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff which is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate checks had been completed before new staff started at the service to ensure they were suitable to work with people. For example, references were sought, and Disclosure and Barring Service (DBS) checks were completed before staff worked with people.

Inspected but not rated

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

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

- The service was unclean and not well maintained. The living room was not person centred, it was in need of re-decoration and the furniture was damaged and in need of replacing.
- Some people's bedrooms were personalised; however, three people's rooms were sparse, and not personalised. The registered manager informed us some people could damage their own property; however no adapted furniture had been sought or considered for people to make their bedrooms person centred and homely.
- When people moved into the service, there had been a lack of assessment considering the adaptations needed to the service to meet their needs. When people had presented with behaviours that were challenging, the registered manager failed to re-assess the environment to ensure it met people's needs. For example, there was very little consideration given to reinforced furniture or blinds or curtains that could not be removed from the walls.
- The carpet throughout the service was in poor condition. In one person's bedroom the carpet was a trip hazard into their bathroom, this had not been addressed by the registered manager.
- The garden of the service was un-useable with rubbish littered throughout.
- The registered manager did not have a maintenance plan in place to address the shortfalls identified during the inspection.

The provider had failed to properly maintain the service. This is a breach of Regulation 15 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.

● Staff and the registered manager lacked understanding around the MCA. Staff and the registered manager made decisions about people's care and support without speaking with people or considering people's best interest and involving other stakeholders.
● Unnecessary restrictions had been placed on people which were not the least restrictive option and had not been reviewed. The kitchen door had a lock on it, and people were unable to access the kitchen freely. One person was given their shower gel when they showered in a medicine pot. Staff told us this was because they used too much shower gel. One person's windows were locked shut. There was no toilet paper in bathrooms, and staff told us this was because people could misuse or overuse it. There was no MCA or best interest meeting around these decisions.
● Incident reports detailed that people were told to stay in their rooms until 'calm' following and during incidents. The registered manager failed to identify the risk of seclusion to people. The registered manager had not considered if this was the least restrictive action.
● Some people had DoLS in place with conditions that had to be adhered to, such as ensuring that MCA were in place for decision making around the person's care. We found those conditions had not been met.

The provider had failed to implement consistent practice with regard to obtaining and documenting consent for care and support. This is a breach of Regulation 11 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.

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

- There was a negative closed culture at the service, which placed people at risk of psychological abuse. People's human rights had not been upheld. Two people had no curtains in their bedrooms. These had not been re-ordered or alternative items ordered. This infringed on people's dignity.
- People were subject to punitive consequences if staff did not agree with actions or behaviours they displayed. For example, during incidents people were 'sent to their room.' During an incident a person was told they were not allowed to get a catalogue 'due to their behaviours.' Daily logs evidenced when people got up 'late' they were told they had missed breakfast and therefore only offered fruit for breakfast.
- Staff used negative derogatory language when speaking with or describing people. People were told their behaviours were 'silly' and incident reports stated people were 'whinging' and 'having paddies.'
- People were not valued; people looked unkempt with dirty stained clothes. One person did not have pillowcases revealing stained dirty pillows. Bed sheets looked old, not matching and their duvet was on inside out. This was not an empowering person-centred environment for people's home.

The provider had failed to ensure people were treated with dignity and respect. This is a breach of regulation 10 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- There had been a complete lack of oversight and governance from the registered manager and the provider. The registered manager confirmed they had not completed any audits for over a year. There was no review of care plans or risk assessments following incidents placing people at significant risk of incidents re-occurring.
- The registered manager failed to identify that risk assessments were not in place for known risks. This included visible risks to the environment, and known risks relating to people's behaviour, health and wellbeing.
- The registered manager and provider failed to monitor and improve the culture of the service. The registered manager and provider failed to identify and act on the negative culture within the service.

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

- There was a lack of collaborative working with stakeholders. The registered manager and provider were insular, and this placed people at harm. The registered manager had just signed up to one external forum

but was unable to demonstrate any learning from this.
● Staff and the registered manager were not always open and honest with other healthcare professionals. For example, one person's care review detailed they had not had any incidents, however we reviewed an incident in which the person had been restrained.
● People were not involved in the service or asked for their input into its running and improvement. During the inspection, one person asked the registered manager if they could have some new furniture. The registered manager responded to say the person had been 'silly' with their furniture
● People had regular keyworker meetings with staff, however these were ineffective. For example, one person had no goals detailed for the period of October 2020 to January 2021. These were not person-centred sessions to support people to achieve their aims and dreams.

The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate and complete records for each person. The provider had failed to improve the quality of the service. This is a breach of regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager and staff showed a lack of understanding of current guidance and legislation, including lack of knowledge or risk management around the spread of covid-19. Staff and the registered manager disregarded the MCA and made decisions without consenting people or seeking their best interests.
● People had been unlawfully restrained and restricted in their homes.
● Multiple incidents had not been reported to the local authority safeguarding team or to the CQC as is required.
● The law requires providers to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. Incidents had not always been reported to the local safeguarding authority or to the CQC as required by law. We could not be assured that the registered manager and provider could meet this requirement.

The provider failed to notify the CQC of safeguarding incidents which is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the CQC of safeguarding incidents.

The enforcement action we took:

Urgent NoD conditions imposed

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:

Urgent NoD conditions imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to implement consistent practice with regard to obtaining and documenting consent for care and support

The enforcement action we took:

Urgent NoD conditions imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks

The enforcement action we took:

Urgent NoD conditions imposed

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 failed to protect people from abuse and improper treatment

The enforcement action we took:

Urgent NoD conditions imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to properly maintain the service.

The enforcement action we took:

Urgent NoD conditions imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate and complete records for each person. The provider failed to improve the quality of the service.

The enforcement action we took:

Urgent NoD conditions imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff

The enforcement action we took:

Urgent NoD imposed