Community Homes of Intensive Care and Education Limited

Beech Tree House

Inspection report

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Date of inspection visit:
14 November 2019
18 November 2019
21 November 2019

Date of publication:
24 January 2020

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

About the service
Beech Tree House is a residential care home for up to eight adults with learning disabilities and/or autism. The service is provided over two floors. Each person has their own bedroom and en-suite, with shared areas such a lounge, dining room, bathroom, quite room, sensory room, and activities room. People had access to a garden area at the rear of the property.

The service has not been developed in line with the principles and values that underpin Registering the Right Support. It did not ensure that people who used the service could live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to eight people. Eight people were using the service at the time of our visit. This is larger than current best practice guidance. There were deliberately no identifying signs, intercom, cameras, industrial bins, or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

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

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

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons, lack of choice and control, limited independence, limited inclusion, limited interaction, and meaningful activities. For example, people did not have choice in the food they ate or at what times meals were served.

People were at risk of contracting infections due to poor levels of hygiene throughout the environment and via staff practices. For example, significant amounts of faeces and urine were found in some people's bedrooms. Staff did not wear appropriate protective equipment when cleaning body fluids up.

People were not protected from unsafe and poorly maintained premises. We found a wide range of maintenance improvements were required around the building. Some of which posed a hazard to people's

health and safety. For example, staff could not immediately access fire extinguishers as they were locked in cupboards and the key was not readily available.

People were not routinely protected from the risk of verbal and physical abuse. Incidents had occurred where people had been harmed. One person's relative told us "I sometimes worry that when I come to the home, will [named person] still be alive? I am extremely worried about their safety…". Although concerns had been raised with the registered manager, they had failed to take the appropriate action.

People were not supported by sufficient numbers of staff. We found the lack of staff had a detrimental impact of people's well-being. People could not participate in activities if the staffing was short. The funding did not equate to the numbers of staff present in the service, for example one person required 15 hours of one to one support by staff each day. We did not see this happen. Each person was funded to have individual support throughout the day, however, the service only employed four staff during the day as a minimum and five as a maximum.

People were not routinely supported with their prescribed medicines by staff who had received training to do this safely. Staff did not consistently follow the providers policies when supporting people with their medicines. For example, we noted the person had not received their medicine 11 times in the month of November 2019.

People were not routinely supported to eat balanced and nutritious meals. Food items listed on past menus did not consistently contain fruit and vegetables. People were only offered one choice at each meal.

Staff were not always supported to carry out their role to the best of their ability. We were told by the registered manager new staff received an induction and completed the care certificate. We asked to see evidence of the completed care certificate, but this was not given to us. People's relatives did not feel staff were suitably trained to carry out their roles.

The service did not routinely support people in line with the Mental Capacity Act (MCA) 2005. People had been assessed as having the capacity to consent to certain restrictions, but this was questionable. For example, consent was given for staff to carry out physical interventions. This was not time specific.

People's relatives felt staff did not treat people in a way that was kind and compassionate. Three relatives told us they did not trust the staff. One relative felt their family member may have been discriminated against. People were not routinely provided with dignity and respect for example, over heard a member of staff speaking in a derogatory manner to a person.

Relatives told us they did not have confidence to raise concerns or complaints. One relative told us "I wouldn't feel comfortable raising a concern, it wouldn't be taken seriously". Other comments included "I have raised concerns with the manager, I don't feel the complaint was listened to. It is only in the last three weeks they are now listening to us".

People's relatives told us their care wasn't reviewed regularly, one relative took it upon themselves to organise their family member's review, as the provider was not forthcoming in doing so.

Activities were provided at the service for people, but these were not always the most relevant or age appropriate. For example, messy play, story time, or garden time in the evening in winter.

Although there was a registered manager in post, there was a lack of clear leadership and overview of the

service. Staff practices were not up to date and person centred. Staff spoke positively about the support they received from the registered manager, however, we found a service that was poorly managed, and this had impacted on people's welfare.

People were supported to healthcare appointments when needed. Care records showed that people were supported to attend routine healthcare appointments with GPs, dentists, opticians, community behaviour support teams and learning disability and mental health specialists.

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 24 October 2017). At this inspection we found the standard had not been maintained and there were multiple breaches of regulations.

Why we inspected
The inspection was prompted in part due to safeguarding concerns received about the conduct of staff and the environment. A decision was made for us to inspect and examine those risks.

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

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

Enforcement
We have identified breaches in relation to Regulations 9, 10, 11,12,13,14, 15, 16,17 and18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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? The service was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Beech Tree 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.

Inspection team
On day one of the inspection the team consisted of two inspectors and an inspection manager. The same two inspectors visited the home on the second day and the evening of the third day of the inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service which included notifications they had sent us. Notifications are sent to the Care Quality Commission (CQC) to inform us of events relating to the service which they must inform us of by law. We looked at previous inspection reports. We used the information the provider sent us in the provider information return (PIR). 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 sought feedback from the local authority and professionals who work with the service. We spoke with members of the public who wanted to share information with us.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the nominated individual, registered manager, assistant regional director, assistant manager, and social care workers. Following the inspection we spoke with the acting manager.The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with several local authority professionals and health professionals who work directly or indirectly with the service.

Inadequate

Is the service safe?

Our findings

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

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

Preventing and controlling infection

At the last inspection we recommended the provider had effective monitoring systems in place to ensure the cleanliness and hygiene of the home. At this inspection we found the provider had not made the required improvements.

- People were at risk of contracting infections due to poor hygiene. On day one of the inspection we found faeces and urine on the floor, walls and bedding in people's bedrooms and en-suites. We found bed linen was stained and had been left on beds.
- The kitchen was unhygienic. We found the oven to be thick with grease and had old cooked food items present. The temperature probe used to take the temperature of cooked food had remnants of food on it.
- People were not protected from the risk of the spread of infection as staff did not follow infection control procedures. For example, a member of staff who was asked to clean a bathroom when we raised concerns about the cleanliness did not wear an apron to carry out this task. This could have resulted in cross contamination as they went about their other duties working with people using the service. Another member of staff was also seen cleaning faeces from an en-suite and bedroom floor without wearing protective shoe coverings again posing a risk of cross contamination.
- There was a lack of managerial oversight regarding the cleanliness of the building. A new cleaning rota had commenced; however, this was not routinely completed. Systems were not always followed to ensure people were protected from body fluids when cleaning.
- We discussed our concerns with the registered manager and the provider's assistant regional director. On day two of the inspection we were informed a deep clean of the service premises was arranged for the following day. On day three of our inspection we still found areas within the home which had not been cleaned. For example, we found urine and faeces on two people's bedroom floor

People were exposed to an unhygienic environment. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were not routinely protected from unsafe premises. We found blind cords had not been secured. This presented a risk of strangulation. This had not been picked up by the provider's health and safety checks. The kitchen bin was broken which meant staff had to use their hands to open the lid. The downstairs toilet was broken and there was no lock on the door. The oven door was broken. One person had no wardrobe doors. We were told these had been reported to maintenance for mending, however, the wardrobe doors were an outstanding piece of work from January 2019.

● Although we found risk assessments had been written they did not provide adequate guidance for staff. For instance, a fire risk assessment had been reviewed by the registered manager on 7 November 2019. It stated that all fire extinguishers were 'readily available', however, we found they were locked behind a door. Keys were held in the staff office and would not be routinely available in the event of a fire.
● People were not protected from the risk of fire. Although staff had completed fire drills. We found one person's room could not be opened with ease. We observed a member of staff struggling to open the door. They told us "This often sticks", we observed the member of staff kicking the door when trying to open it. The staff then removed a strip of metal on the bottom of the door and was then able to open it. At this time, we were unaware a person was in bed. If staff had not been familiar with the door and a fire had broken out, they may not have been able to get the person out.
● We found the filter from the tumble dryer was full and had not been cleaned. This posed a significant fire risk. The registered manager cleaned this when we pointed this out to them.
● A person had an allergic reaction to a food item. Records did not show a risk assessment was in place to guide staff on how to minimise the risk, or how to respond when a reaction occurred. We were sent a risk assessment for this person after we had pointed it out to the registered manager.

Using medicines safely
● People were not routinely supported with their prescribed medicines by staff who had received training to do this safely. Staff did not consistently follow the providers policies when supporting people with their medicines. For instance, the providers' policy stated, "Use disposable gloves per person when applying creams or ointments". We observed a member of staff applying cream to a person without the use of gloves. We discussed this with them and advised a senior member of staff.
● We read a note in a communication book asking staff to ensure they picked up a person's prescribed medicine from the pharmacy. We noted the person had not received the medicine 11 times in the month of November 2019. A member of staff told us the medicine had not been picked up and therefore was not in the home for over five days.
● People were routinely supported with their medicines in the staff office. This did not ensure they received a dignified service and had the potential for staff to be distracted.
● We found the medicine cabinet and associated items to be unclean. A pill medicine counter was thick with residue. We had to prompt the registered manager to clean this prior to them using it.
● The systems in place to monitor medicine stock levels were not effective. Audits carried out by the registered manager did not highlight some of the issues we found. We found inaccurate stock levels recorded and four creams which should have been disposed of as they had been opened for too long. Not all creams which needed to have a date of opening had one.
● One person had a hand-written medicine administration record (MAR). We found this had not been signed by the member of staff who had written it. This was not in line with the providers policy.

We found no evidence that people had been harmed. However, the provider had failed to ensure people were protected from avoidable harm. The provider also failed to ensure people were supported with their prescribed medicines in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse;
● People were not routinely protected from the risk of verbal and physical abuse. We had been made aware of allegations of physical abuse by staff on people. These had been investigated by the police and through an internal investigation. We were told one allegation had been unsubstantiated and another partially substantiated.
● We had further concerns related to the lack of action taken by the registered manager towards

information shared with them by external professionals. They had not followed the correct procedure and as a result had not protected people from the possibility of abuse.
● People were placed at risk of being hurt by each other. Some people displayed behaviours that had the potential to harm others and staff. We found staffing levels did not reflect the support required to keep them safe.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding procedures were not always followed.

Staffing and recruitment
● People were not supported by enough staff. We found the lack of staff had a detrimental impact of people's well-being. One person was observed to be sitting in the staff office, while another person was supported with their medicines. We asked a member of staff why the person was in the office. They told us "I am doing personal care…I need to witness the meds… so I will take [Name of person] upstairs after".
● People were funded for one to one support, and the provider assured us that the service was staffed sufficiently to ensure people received their individual support. However, we found people did not always receive this one to one support. We observed on more than one occasion one member of staff with three or more people all who should have had one to one funded support at the time. On one occasion we observed an agency staff member working alone with four people. It was only their third visit to the service.
● Staff and people's relatives told us there were not enough staff, this led to people's activities being cancelled. People then became bored, and their behaviour was then difficult to support. Staff also told us because there were insufficient numbers of staff they were not able to keep the service clean. They were responsible for cleaning the service as well as supporting people, some of whom needed one to one support.
● On the first day of the inspection we saw one staff member was emotionally upset and physically drained. When we asked them why they were upset they told us they had worked 39 hours over three days, these hours included a sleep-in duty, during which they told us they had had disturbed sleep. They were tired and emotional. According to the rota another staff member had worked 75.5 hours over six days, during this time they were expected to work an additional sleep in and were on call for two nights. This was not safe practice.

There was a lack of staff to fully meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding procedures were not always followed.

● Systems were in place to ensure people were protected as far as possible from unsuitable staff. Checks included Disclosure and Barring Service (DBS) checks, written references, health declarations, and proof of identity and of address. Where there were gaps in candidate's previous employment histories these were explored and recorded.

Learning lessons when things go wrong
● Accidents were appropriately recorded and indicated that action was taken to prevent reoccurrences. For example, seating arrangements in the service vehicle had been reviewed following one accident. However, records indicated that staff had been slow to react to one person's behaviour escalating and this had resulted in a staff injury.
● Records showed staff had been reminded about following people's positive behaviour support plans in response to this incident. However, it was unclear how this was being monitored.

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 deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support, and outcomes.

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

- People were not routinely supported to eat balanced and nutritious meals. Food items listed on past menus did not consistently contain fruit and vegetables. For instance, we found lunch time choices including macaroni cheese, pizza, and chicken Kiev and an evening meal was often sandwiches or food on toast.
- One person had a history of being underweight. Their weight was monitored monthly; however, this had not been recorded in October despite a steady decrease in weight over several months of four kilograms (eight pounds eight ounces). Their care plan stated that weight loss of over five pounds in one month or a stone over a period of several months should be reported. This would have amounted to concerning weight loss before any support was sought from healthcare professionals.
- People who required support with their meal had this provided. However, we observed this was not always provided in a dignified manner. On the second day of the inspection we observed one person being supported with their breakfast. The member of staff was disengaged and barely spoke to the person. We provided feedback to a senior member of staff.
- Two people's relatives told us when the person went to spend time at the family home they appeared to be hungry. They were unsure if this was because they were not eating sufficient amounts of food at the service or if it was because their kitchen was not locked. The kitchen in the service was kept locked to prevent people coming to harm. However, this meant they were reliant on staff to escort them to the kitchen to support them, which meant they did not have free access to food and drinks.
- People were not always fully supported to make food choices that met their needs. For example, the registered manager told us that residents' meetings were used to decide on menus. However, people were only offered one choice at each meal and although pictures were used, more creative ways of supporting to make choices in real time were not used.

We found no evidence that people had health issues associated with a poor diet. However, the provider had failed to ensure people were supported with a nutritious diet that promoted good health. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's needs had been assessed and care plans and risk assessments were in place to guide staff. Care plans reflected people's physical and psychological needs, however, we found they were not always accurate in the information they held. For example, one person's plan stated they received one to one care

15 hours per day for seven days per week. However, when we observed the care provided this was not the case.

● People had positive behaviour support plans in place that had been developed by healthcare professionals. These had clear instructions for staff on supporting people to minimise behaviours that may arise from anxiety, frustration or distress and pose a risk to themselves and others. This include restrictive measures that could be taken.

Staff support: induction, training, skills, and experience

● Staff were not always supported to carry out their role to the best of their ability. We were told by the registered manager new staff received an induction and completed the care certificate when they were employed into the service. The care certificate is an identified set of standards that health and care professionals adhere to in their daily working life. However, a staff member who had been employed for nearly six months told us they had not completed any of the care certificate. Following the inspection, we asked to see evidence of staff completion of the certificate, but we did not receive any.

● Staff received weekly supervision for the first six weeks of their employment, then quarterly supervision and an annual appraisal. Staff completed training as part of their induction and updates were offered periodically after this. One staff member who had been employed in September 2019 had only completed two of the 27 training courses deemed as mandatory for staff working in this service. We observed this staff member speaking to a person in a derogatory manner. They lacked the skills to treat the person in a respectful way.

● We observed a staff member applying cream to a person's feet without wearing protective gloves. They had not been trained in the administration of medicines and therefore should not have been completing the task. They had completed infection control training but had not applied the principles. We observed poor interactions with people, and staff not applying the information they had learned as part of their training to the care of the people in the service.

● People's relatives told us they did not feel the staff were adequately trained to care for people with autism. One person's relatives commented "Staff are not adequately trained, there is a high turnover of staff, so they have to keep training them. Staff have no perception of pain or how [named person] is trying to communicate this to them". Other comments included "Staff should have training in autism". "Staff are not skilled".

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not able to apply their learning and their competency to do the job was not checked.

● Staff meeting were held monthly to discuss issues within the service, and to acknowledge staff achievements.

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.

● The service identified if people had difficulties making informed decisions. They carried out routine mental capacity assessments, when there were concerns about the person's ability to make decisions. However, we were not certain the registered manager had fully understood the requirement of the Act when doing so.

● For example, one person's records stated "[Named person] doesn't have capacity to make decisions. [Named person] can consent to taking part in activities…" This is a contradiction. Any decision being assessed had to be time and decision specific, this wasn't. Another person was reportedly able to give "Informed consent" to staff using physical intervention when needed. They had signed a consent form. It is questionable if at the time a person would be receiving such interventions whether they would be willing or able to consent to this.

●The same person was assessed as able to take control of their own finances; however, this was not the case. The person's finances were dealt with by the registered manager and senior staff who had access to their bank account. Their family member did not feel they did have the mental capacity to make decisions about their finances. This was referred to the care management team to investigate further.

● When we discussed MCA with staff only one staff member showed any insight into the Act, the others had little if no understanding of how it applied to their work.

The service did not routinely support people in line with the MCA 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where restrictions were in place for example, key pads on doors, DoLS applications had been sent in for authorisation and there was a record of these on people's files.

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

● People's rooms were personalised with their chosen likes. One person told us how they liked pictures and they had many displayed on the walls of their bedroom. The communal areas were furnished with basic furniture, such as couches, a television in the lounge, and a table and chairs in the dining area.

● Many areas of the building required maintenance, for example in the communal bathroom area the floor needed replacing. The washing machine required a soap dispenser, and in a downstairs room there was a significant amount of mould on the wall. Kitchen equipment was broken such as the cooker door.

● One person required support to install appropriate wardrobe doors in their room. It was noted that this had been mentioned in their January review and in the key worker reports since this time but had still not been actioned, which meant their room remained in a state of disrepair. We brought all these things to the attention of the registered manager, who told us they had reported these to maintenance for repair.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were supported to healthcare appointments when needed.

● Care records showed that people were supported to attend routine healthcare appointments with GPs, dentists, opticians, community behaviour support teams and learning disability and mental health specialists.

● Records showed where people required support from external professionals this was provided. The GP worked with the service to ensure people's health was maintained. Guidance received from professionals was documented.

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 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 were not always well treated and supported. One person's family member told us how they would not discount the fact that their relative may have been discriminated against in the service, but they could not tell us the reason why this had happened. This followed and alleged incident of verbal and physical assault by a staff member. They told us "Until this incident happened I trusted them (staff) 95%, I can't say that anymore".

● Another person's relative told us the staff had respect for them, but not their family member who was living in the service. They told us the staff did not know how to deter the person from becoming anxious and upset, which in turn affected their behaviour.

● A third relative told us they were not satisfied with the care and support their relative received. They felt the service did not support the person to take care of themselves and develop independence skills, something they were told would happen when they moved into the service.

● One person practiced their religion and their care records showed they often used gestures that were significant to their religion and they also enjoyed going to their place of worship. Although the person's family took them to the temple, when asked the registered manager said that staff at the service hadn't considered taking the person themselves to enable them to participate in this activity at other times.

● People were not routinely provided with dignity and respect. Staff did not always demonstrate that they were kind and compassionate. We observed staff supported people without speaking with them. For instance, one person had an apron put on them prior to eating their breakfast and the member of staff did not ask their permission or inform them what they were about to do. Another person was supported to wipe their hands following a meal. The member of staff walked up to them, picked up their hands and wiped them with a damp cloth.

● On the third day of the inspection we walked into the lounge and overheard a member of staff speaking in a derogatory manner to a person. Another person made the member of staff aware of our presence, and they immediately stopped talking at the person. We made the provider aware of this following the inspection.

● We noted some of the language used by staff and in records was not appropriate, professional, or dignified. For example, people were described as "kicking off' and "had a wobble."

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

● People were not all able to express their views verbally. However, people did have family members who could speak on their behalf. When speaking with some family members we were told there was a lack of

communication from the service, and they were not always informed when things went wrong or there were changes within the service.

● One relative told us they had to organise and coordinate a review of care for their family member as it had been over two year since their care had been reviewed.

● Another told us they would like the care to be reviewed, and they would like to be part of this process, they felt they were not kept informed by the service about how their family member was, they said, "They (the service) don't tell us anything". We fed this back to the provider who agreed to take appropriate action.

● A third relative told us how they had repeatedly asked for support for their family member to increase their independence. They told us this had not happened. Care plans did record people's preferences and dislikes. However, the service was very institutionalised in its day to day organisation, and people had to fit in with the service rather than the other way around. For example, when short of staff, activities were cancelled. Meal times were set, and people had no choice of what or where to eat.

People were not routinely treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Outstanding. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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.

- There was a lack of personalised care being provided to people. Activities did not always meet people's needs or interests. Staff did not routinely demonstrate they were able to communicate with people. Some staff had received intensive interaction training (A way of communicating with people by mirroring sounds, actions, and movement). We did not see any staff members implement what they had learnt with people. Not all staff had received training on how best to communicate with people. People communication needs were recorded. This included speech, hearing and sight difficulties.
- One person had English as a second language. Although they had limited verbal communication, they did have some understanding of language. We asked the registered manager if any staff were able to speak with the person in their first language. The registered manager said that a couple of members of staff could speak a few words, but this was limited. We asked if staff had considered learning key words in the person's first language to support communication, but the registered manager said this had not been considered.
- Not everyone in the service could express their views about their care verbally. Some people communicated their views through facial expression, body language and behaviour. However, this was not always viewed as a form of communication. For example, one person's support records stated the person self-harmed "for attention". When the person told staff, they had self-harmed staff were to "Ignore this as he has done it for attention". Their positive behaviour plan highlighted the person had triggers which could escalate challenging behaviour, some of these were "Withdrawal of attention from staff…not feeling listened to…rejection". It was evident how staff interpreted people's communication could have a detrimental effect on their wellbeing.
- We also observed that staff used inappropriate language when talking to people, unacceptably asking for hugs, and speaking to people as though they were children. In addition, we observed staff had limited meaningful interaction with people. For example, during a baking activity a member of staff was observed decorating biscuits whilst having no engagement with the person who was in the kitchen during the activity. We also saw another member of staff not engaging with people and spending significant amounts of time using their mobile phone or watching television.
- During the three visits to the service we did not witness staff use any alternative forms of communication other than speech with people. We saw no use of tools such as objects of reference, pictures, symbols or signing to support people's communication. There were some symbols and picture boards on walls, but these were broken and unused.

The service failed to facilitate the most suitable means of communication for people. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were some social stories in files for use at particular times, for example, to prepare for healthcare appointments.

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

● People's care was not personalised, activities were not always purposeful or relevant to the needs or interests of the person.

● The service supported people to maintain relationships with their families. People were enabled to visit the family home. Activities were provided at the service and a recorded plan was in place for each person. However, we had some concerns as to the validity of some of the activities. For example, one activity for the evening was "wiping tables". Another was "Garden time". We spoke to staff who informed us the garden time was in the summer, however we found this was recorded for one person for four evenings in one week in November. We followed this up with the acting manager after the inspection, they told us they had checked the daily records, but found no reference to the person being in the garden. The records were vague, so it was difficult for them to say what the person had been doing on those evenings.

● We also saw reference to "Story time" and "Messy play". Both terms were patronising as they were referring to activities for adults not children.

● We reviewed the day activities for seven days. During this period, an activity of "Drive out" occurred on five out of the seven days. This was where people went out in the vehicle. There was no destination or purpose recorded on the plan. One staff member told us this was often used to just drive around, when they were short of staff. A relative told us their family member was driven around and sometime went to head office. This was not a meaningful activity for people.

● Staff told us the first thing to suffer when they were short of staff were the day activities. This led to people being bored and an increase in people's challenging behaviour.

People were not always provided with activities that protected them from social isolation. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some activities were in line with people's interests. For example, music therapy and swimming. Records showed these had taken place.

Improving care quality in response to complaints or concerns

● Relatives told us they did not have confidence to raise concerns or complaints. One relative told us "I wouldn't feel comfortable raising a concern, it wouldn't be taken seriously. I would go to [named social worker] to raise a concern. I think they (staff) would listen but not respond.

● Another person's relative told us they were not sure how to raise a complaint.

● A third said "I have raised concerns with the manager, I don't feel the complaint was listened to. It is only in the last three weeks they are now listening to us".

● A fourth relative told us they had met with the senior staff at the service and had been told they needed to trust the staff. They told us they were unable to do so, as they did not feel the staff took reasonable care of their family member. They told us they did not trust the abilities of the staff to keep their family member safe. They were going to raise a formal complaint.

The provider did not always investigate thoroughly and take necessary action when failures were identified. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed some complaints had been responded to appropriately and letters of apology sent where this was appropriate.

End of life care and support

● People's end of life wishes had been considered. One person's care plan included information about important aspects of dying in relation to their religion and stated that the person had been shown a video to support their understanding of this. Another person had an after-death care plan, which recorded their funeral wishes.

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 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

- We observed staff were disengaged and did not demonstrate they wanted to help people to achieve good outcomes. The culture in the service was not positive. The staffing arrangements in the service did not lend themselves to staff being deployed to assist people in the most appropriate way. For example, people did not receive the one to one support they were funded for.
- Poor practice was not challenged. People were expected to attend the office to receive their medicines. People were expected to be observed cleaning their teeth in the office, regardless of the presence of visitors. This was not person centred and did not protect people's dignity. All staff were aware of this practice, but no action had been taken to change this.
- The people who were using the service who had no-verbal communication were not given sufficient tools to enable them to communicate their needs. A menu plan was on the kitchen wall, but this was very small and not in a place where it could be used effectively to support people's communication and choices.

The design and delivery of care did not always meet people's needs. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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

- There is a legal requirement for providers to be open and transparent. We call this duty of candour (DOC). Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation. The provider had a duty of candour policy. Only one out of the staff we spoke with had any understanding of its meaning or purpose.
- People's relatives told us the culture was not open and honest. Comments included "I don't think anyone there would be honest and open, only [named staff member]". One relative told us "There is not enough staff, there is not enough stimulation and interaction". Another said "Sometime I see him; his hair and nails are long. I am worried because he is losing weight".
- Another said "I sometimes worry that when I come to the home, will [named person] still be alive? I am extremely worried about their safety… When I have raised concerns, I am told I am "anxious". I am not anxious I am a mother, and this is my duty. I am not happy at all about the quality of care".
- We received information from an external source which demonstrated how the registered manager failed to be open, honest, and transparent when concerns were raised with them. They had failed to report the concerns to their manager or to take appropriate action to protect people. In doing so they placed people at

risk of harm.

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

● Although there was a registered manager in post, there was a lack of clear leadership and overview of the service. Records were not routinely updated or kept accurate. We found gaps in routine health and safety checks. The registered manager acknowledged this and told us "I have recognised that there is stuff that is missing, one month is particularly bad".

● Systems put in place to monitor health and safety were not always completed. For instance, weekly fire checks had not always been carried out and water temperatures had not been routinely recorded.

● An external professional made a complaint to the registered manager about the conduct of a staff member. During our visit we followed this up and asked what action had been taken. We were told the staff member had been spoken to by the registered manager, but this had not been documented. No further action had been taken. The information had not been passed to the provider's senior managers. The assistant regional director told us they had not been made aware of the concerns. Due to the seriousness of the concerns we asked the assistant regional director to take appropriate action.

Continuous learning and improving care

● The service did not always learn from past mistakes and put in place action plans for future improvements. From reading the minutes of the staff meetings we could see there were standard agenda items such as safeguarding, whistleblowing, cleanliness of the service, and time keeping. We noted the cleanliness of the service had been an issue since April 2019, with only one record referring to improvements made. Issues raised at the meetings were not always followed through by the senior staff.

● Apart from medicines, staff competency was not assessed. It was clear from our visits, that staff did not have the skills to carry out meaningful, person centred care in a respectful way. There was a lack of evidence of staff being able to demonstrate meaningful interactions with people. Systems were in place that were outdate and institutionalised. These had been established and were no longer appropriate. For example, having to ask for toilet paper, soap and towels when visiting the toilet. Some activities such as driving around in a vehicle were meaningless. Since our last inspection there was a significant lack of progress in the care being provided at the service.

● There was a lack of clear leadership within the service. We had been told by a member of the public of inappropriate behaviour by the registered manager and staff. For example, we were told staff often sat in the office using their mobile phones. On the evening of our visit, when we arrived two staff were sat in the office using their mobile phones.

● We were also told when staff raised concerns about other staff's conduct the registered manager failed to take appropriate action. Audits carried out by the registered manager did not highlight some of the issues we found in relation to health and safety, medicines, and infection control.

The lack of effective management had placed people at risk of harm, this was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● At the time of our inspection the service was working in partnership with Bucks Community Learning Disability Health Team to learn how to engage with people in the service appropriately. This included how to support people in a way that would aim to minimise difficult behaviours and increase good practice.

● Staff worked alongside other professionals such as speech and language therapist, day service staff, and the GP

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

- Some consideration had been given to people's equality characteristics, but the support was not always appropriate. For example, we were told how work had been undertaken to support a person to join their family in the family home at Christmas. When asked we were told the person was not a Christian, and there may have been more appropriate festivals for the person to share with their family.
- Other people's sexual needs had been established, and appropriate support had been given to people.