Manchester City Council

Hall Lane Resource Centre (Respite Care, Short Breaks Service)

Inspection report

157-159 Hall Lane
Baguley
Manchester
M23 1WD

Tel: 01612192413

Date of inspection visit:
31 August 2017
07 September 2017

Date of publication:
01 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Hall Lane Resource Centre provides respite and short break accommodation for people who require support with personal care. The centre can accommodate up to 10 people. The centre is located in a residential area of Baguley, close to local shops and transport links. At the time of our inspection, there were five people living in the centre on a short stay basis.

There was a registered manager in post at the time of our inspection but they had not been in work for approximately eight months prior to our inspection. They were not present at the inspection and the inspection was supported by an acting manager who supported the centre on a part time basis.
A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

During this inspection, we found breaches of Regulations 9, 10,12,13,16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our enforcement options in relation to these breaches.

We looked at three care plans. Two of the three care files we looked at failed to clearly identify people's needs and risks. We found that some of the risks in relation to people's care had not been risk assessed and some of the risk management information was contradictory and confusing for staff to follow. This placed people at risk of receiving inappropriate or unsafe care. By day two of the inspection, the acting manager had taken some steps to address this.

We saw that in two out of the three care files we looked at staff had information on the person's likes and dislikes, personal hygiene preferences and daily routines. There was also some good information on people's personal history and their ability to communicate. In one of the files we looked at, sufficient information in all these areas was missing. By day two of the inspection, action had been taken to address this.

We found that improvements with regards to how the service assessed the capacity of people to participate in and consent to the planning and review of their own care was required in order for it to comply in full with the Mental Capacity Act. We saw however that no major life decisions had been made about people's care. For example, a deprivation of liberty safeguard or do not resuscitate decision. Care plans contained sufficient information about how people communicated their wishes for staff to determine if they consented to their day to day care.

We found that safeguarding incidents were not always recorded, investigated or reported appropriately. Incidents of a safeguarding nature had not always been identified and responded to and the provider lacked a robust system to protect people from the risk of abuse.

Medication was not always stored securely. Prescribed creams and other prescribed medication such as antibiotics were found on display in people's bedrooms. This placed them at risk of unauthorised use. Some people's medication administration charts were confusing and open to interpretation. This meant there was a risk that staff would not have the same understanding of how to administer the person's medication in order to ensure it was administered safely. We found gaps in the administration of one person's lunchtime medication. When we investigated this further, we found that the service had no protocols in place to ensure the person received this medication when they were away from the service.

There was mixed feedback from the people and relatives about whether the number of staff on duty was sufficient to meet people's needs. Staff supervision records showed that staff had raised concerns about poor staffing levels and the impact this had on the ability of the service to provide safe and appropriate care. We found no evidence that these concerns had been acted upon by the management team. The service had a small team of permanent staff but relied on agency staff to plug gaps in staff rotas where one to one support for people was required. When we looked at the staffing system in place we found it to be overcomplicated and ineffective and there were times when due to this, the service was left understaffed. This placed vulnerable people at increased risk of unsafe and inappropriate care.

We saw that staff had received supervision in their job role but found this supervision was not always supportive as staff concerns had not always been responded to. There was evidence that the skills and abilities of staff were appraised but we found the appraisal process to be generic and not centred on the individual. Staff training was not up to date and some staff lacked sufficient training to enable the provider to be assured they could do their job role effectively.

We saw that there were a significant number of concerns raised by people's relatives about people's personal belongings not being returned when the person returned home. We found little evidence that these concerns had been addressed and little evidence that the provider had a system in place to ensure people's personal belongings were secure. This did not indicate that people's personal belongings were treated with respect.

People told us that the majority of staff treated them well. Most of the staff we observed supported people in a kind, caring and patient manner. We saw that most staff were person centred in their interactions with people and ensured people's choice was promoted in the day to day delivery of care. Some of the agency staff we observed although kind and attentive when people required support sometimes failed to interact with the person they were supporting in any meaningful way.

People told us the food was good and that they got enough to eat and drink. During our visit, we saw that people's meals were provided in a person centred way. For instance, at a time when the person wanted their meal, as opposed to set mealtimes and people had unlimited access to drinks as and when they required them.

Some of the people who stayed at the centre, attended a day centre, a separate service, located on the ground floor of the same building. The acting manager told us the day centre provided a range of activities. We found however that if people did not want to attend or were unable to attend the day centre, there were no alternative activities or outings organised by the provider for them to participate in during their stay. This did not indicate that people's social and emotional needs were assessed, planned for and met by the provider.

This service was not well-led. The service lacked adequate local management and governance arrangements. The system in place were centralised to the Local Authority and did not enable local

intelligence to be analysed and monitored by the service itself so that service specific improvements could be made. There were no local audits in place to assess, monitor and mitigate risks in relation to people's care, accident and incidents, safeguarding, medication, staffing and staff support or people's views and opinions on the service provided. This meant that the concerns we identified during our visit had not been identified or addressed.

At the end of our inspection, we discussed the concerns we identified during the inspection with the acting manager and other senior managers from the Local Authority. They accepted the concerns we had raised with regards to the service. We also raised concerns about their failure to consistently notify the Commission of notifiable incidents.

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.

People's risks had not been properly assessed and care files contained contradictory information about people's needs and care.

Safeguarding allegations were not properly documented, investigated, reported or responded to by the provider.

Staffing levels were not always sufficient or properly organised to ensure people's needs were met at all times.

Medication was not stored or managed safely. The service failed to ensure safe management protocols were in place.

The premises were found to be clean and adequately maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

The assessment of people's capacity to participate and consent to their care required improvement for it to comply in full with the Mental Capacity Act (2005).

Staff received supervision in their job role. Staff were not adequately trained and the appraisal of staff skills and abilities was not always centred on the individual.

People told us the food was satisfactory and they got enough to eat and drink. People had a choice of meals and were able to choose their mealtimes.

Is the service caring?

Requires Improvement

The service was not consistently caring

People's personal belongings were not always treated with respect. Sometimes people were given other people's clothes to wear. This did not show that the service always treated people

and their belongings with respect.

The majority of people who lived at the home and their relatives said the staff were kind and treated them well. Our observations of care confirmed this.

Is the service responsive?

Inadequate

The service was not always responsive.

People's care files contained information about the person, their likes and dislikes and preferences in relation to their care.

Staff interactions with people were person centred but the care provided did not always meet people's needs in a person centred way.

People had no access to any social or meaningful activities in support of their emotional well-being.

The provider had no effective system in place to identify and address any informal concerns and complaints received about the service.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance systems in place were ineffective and inadequate. They did not identify and address the risks to people's health, safety and welfare. This meant people were placed at risk of avoidable harm.

The provider's governance systems failed to provide the service with any meaningful information about where improvements were required.

People's satisfaction with the service had not been sought to enable the provider to come to an informed view of people's satisfaction with the care provided.

Hall Lane Resource Centre (Respite Care, Short Breaks Service)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place 31 August and 7 September 2017. The first day of inspection was unannounced and undertaken by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second day of inspection was announced and completed by two adult social care inspectors.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We used this information to plan our inspection.

At this inspection we spoke with two people supported by the service and four relatives. We also spoke with the nominated individual, the acting manager, the care co-ordinator and two staff members. At the end of the inspection, we fed back a summary of our findings to the acting manager, the nominated individual and two other senior managers at the Local Authority

We examined a range of documentation. This included the care files and day to day records belonging to three people who lived at the home, staff training and support records, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

The two people we spoke with told us they felt safe. One person said "Yes, I enjoy the break and the peace and quiet from my parents". The other person said "Yes I feel safe. Doors are always secure. Security on in the evening. Staff look after me".

The care staff we spoke with demonstrated that they knew what action to take to protect people from the risk of abuse. However records showed that they did not always take this action when required. We found that the way the provider identified, documented, responded to and reported incidents of potential abuse was inadequate and did not ensure people were sufficiently protected from risk.

For example, records showed that one person had advised staff they were going out but had not returned to the centre by the pre-agreed time of 10pm. The person was reported missing to the Police and their whereabouts were unaccounted for, for a period of time. Despite this, the incident was not properly documented or reported by the provider to either the local safeguarding team at the Local Authority or the Care Quality Commission (CQC). There was no evidence that the provider had investigated the circumstances leading up the person going missing or reviewed the safety arrangements in place to support the person's ability to leave the centre unsupervised. Records showed that three days later the person went out again and failed to return to the centre until the next day. The provider had no evidence that this second incident was investigated, documented and reported in accordance with local safeguarding procedures or CQC legislation.

One relative we spoke with told us that after their relative had recently stayed at the centre, they had returned home with unexplained bruising. They told us that when they asked about this, none of staff knew anything about it. Unexplained bruising under safeguarding procedures is considered a potential safeguarding event and should be investigated and reported to the local safeguarding authority and CQC. When we checked the provider's safeguarding records, we could find no documentation in relation to this person's unexplained bruising, the concerns expressed by the relative or evidence that an investigation into how the person sustained these injuries had been undertaken. When we spoke with the acting manager about this, they were unaware that the person's relative had reported these concerns to staff at the centre.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have robust procedures and processes in place to protect and safeguard people from potential abuse and to take appropriate action should abuse be suspected.

We looked at the way people's needs and risks were assessed and managed. We found that in two out of the three care files we looked at, risk assessments and risk management plans were poor. For instance one person had come to live at the centre at short notice. We saw their care file contained little information about the person's needs and risks. The provider had made no attempt to assess the person's needs or risks themselves on admission and on the first day of our inspection, a week after the person had been admitted, this information had still not been collated. This meant staff had little information on what the person's

needs and risks were and little guidance on how to provide the person with safe and appropriate care.

One person who had stayed at the centre several times had complex needs. These complex needs made them particularly vulnerable to ill health. When we looked at their care file we saw they had numerous risk assessments and management plans in their file from other health care providers that supported the person when living in the community. There was little evidence however that the provider themselves had risk assessed or planned the person's care. The risk management information in the person's care file was contradictory and confusing. It was difficult to determine which risk assessments and management plans were up to date or the correct ones for staff to follow in the delivery of care. The person's complex needs placed them at serious risk of ill health if staff followed the wrong risk management guidance. We spoke with the acting manager and care co-ordinator about this and expressed our concerns.

On day two of the inspection, the acting manager had taken some action to address our concerns regarding the assessment and risk management of people's care.

This evidence demonstrates a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

On the days we inspected, people's needs were supported by a mixture of permanent and agency staff. The acting manager told us agency staff were used when people required one to one support for their needs. We were told that a central resource team at the local authority organised the booking of agency staff. The care co-ordinator told us "We don't have a lot of regular staff".

We asked people if the number of staff on duty was sufficient to meet their needs. People's feedback was mixed. One person who had stayed at the centre told us "Sometimes they are short staffed, but they use agency staff and its okay". They went onto say "The staff know me well- except when its bank staff. Due to cutbacks and short staffed times they have no choice but to use them. My only complaint is that they have to use bank and agency staff".

One relative commented "For me staffing has never been a problem. There always seem enough staff around whenever I have been to Hall Lane" whereas another relative said "They are short staffed at times. I think it is all temporary staff they use who get things like their clothing wrong. They (the temporary staff) seem a little bit helpless to me".

Staff we spoke with told us that they thought there were enough staff on duty to support people but staff supervision records showed that several staff had raised concerns about the way the service was staffed. For example, the supervision records of one staff member stated "(Name of staff member) is concerned with lack of consistency in regular staff and agencies. Feels service is unsafe at times". Another staff member expressed concerns that the service was "Not fully staffed and was concerned with the impact this will have up to date on the service".

We asked to see the system for planning staff rotas. We found the system difficult to understand. The rota's we looked at were disorganised and difficult to read and it was hard to tell who was on duty at any given time. The staff communication book contained several entries where the service had been left short staffed either because agency staff had not been booked or because they had not turned up for their shirt. This was particularly concerning as the service was using agency staff to support the most vulnerable people who came to stay and we saw that there were times that people did not receive the level of support they required to keep them safe.

For example, during the months of March to August 2017, staff entries in the communication handbook indicated that there were 12 instances were agency staff failed to turn up for their shift, leaving the service short staffed. This meant three people were sometimes left without the one to one support they required. It was clear from staff entries that there were issues with the planning of staff rotas and the booking of agency staff which made staffing at times unreliable.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were sufficient staff on duty at all times to ensure people's needs were met

We looked at the arrangements in place for the safe storage of medication. We found that some medications were not stored securely. Prescribed medication was stored in some people's bedrooms with no evidence that it was safe to do so. For example one person's bedroom contained a plastic box of prescribed antibiotics, painkillers, liquid epilepsy medication and other liquid medications and laxatives. People's bedrooms were unlocked and doors left wide open, this meant these medications were accessible to unauthorised persons. The temperature at which medication was stored at was also not monitored. Medication can become ineffective or unsafe to use when stored at too high a temperature.

We checked a sample of three people's medication administration records (MARs). We found that one person's stock of medication did not match what had been recorded as administered. The administration instructions that staff were to follow when giving the person some of their medications were unclear and open to staff member's individual interpretation. This meant there was a risk that some staff may administer the medication inappropriately, which could place the person at risk.

This person's medication records showed they regular missed their lunchtime dose of one of their medications. We asked the acting manager about this. They told us that on the days the person attended the day centre downstairs, staff at the day centre gave the person this medication. When we asked them how they knew that the person was receiving this medication however, they were unable to answer. They acknowledged that they did not provide the centre with the person's medication, did not know if the day centre had supplies of this medication, had no evidence that day centre staff were administering this medication and had no procedures or checks in place to ensure the person received the medication they required. This meant they did not know if the person had been given the medication they needed to keep them safe and well.

These incidences demonstrate the way in which some of the medication was stored, administered and recorded was not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations.

The safety of the premises and its equipment was satisfactory and regular maintenance of the premises had been maintained. There were some improvements needed to the electrical installation but we were assured these were in progress. Adequate fire safety and evacuation procedures were in place and regular testing of the centre's fire alarm was undertaken.

On the days we visited we found the centre to be generally clean and tidy but found the fire door to the laundry was propped open for most of the first day. This meant the laundry was accessible to unauthorised persons and also meant that the fire protection in the laundry was compromised, as the fire door when propped open would not prevent the spread of a fire. The laundry area contained washing powders and laundry softener that may be hazardous if used incorrectly. We also found that a bed rail in place on one person's bed was unsafe. When we drew this to the acting manager's attention, this was acted upon

immediately.

There were systems in place to ensure that regular checks of the home's water system were undertaken to prevent the risk of a scalding incident and there were also systems in place to monitor and mitigate the risk of Legionella in the home's water supply.

At the last inspection, we looked at staff recruitment records and found that staff members had been recruited safely. We did not review this again at this inspection, as the acting manager told us that no new staff members had been recruited since we last reviewed this information.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that the staff were nice and looked after them. Most of the relatives we spoke with said that they thought staff had the skills to meet people's needs. One relative said they "Didn't know". Staff we spoke with told us they felt they were well trained. When we checked the provider's training records however, we found some staff had not had their training refreshed for over two years and some staff had not completed all of the provider's mandatory training.

For example, eleven staff worked at the centre either on a permanent or bank staff basis. Of the eleven staff, eight staff had not completed training in health and safety, four had not completed positive behaviour training; five staff had not completed training in the use of physical interventions, and three staff had received no training in how to support people with autism or epilepsy. Nine staff had not had their moving and handling training refreshed for over two years. This meant there was a risk that staff lacked the skills, competencies and knowledge to support people safely and effectively.

We saw that most staff had received regular supervision but found these supervision sessions were not always effective in addressing staff concerns. For example, several staff raised concerns about staff shortages and the use of agency staff but there no evidence that any action had been taken.

We looked at the appraisal records belonging to two staff and saw that the appraisal documentation was generic. It contained almost the same information about the person skills and development needs 'word for word' despite them relating to two different staff members. This did not demonstrate that the skills and abilities of staff members were individually assessed and planned for to ensure they had the necessary skills and abilities to do their job role well.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, effective supervision and appraisal in their job role.

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. We found this legislation was not properly followed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that two out of the three care files we looked at contained information about the person's ability to

communicate. For example, where people had communication difficulties we saw that staff had information on the body language or facial expressions the person may exhibit when they were happy, sad, hungry or tired etc. This enabled staff to interpret people's feelings, wants and needs and helped them determine if the person consented to their day to day support.

We did not see any specific decision making process in the three files we looked at to indicate that any major decisions had been made on people's behalf that would require a MCA assessment to be legally undertaken. For example, a deprivation of liberty safeguard or a do not resuscitate order. But in two out of the three care files we looked at, we found that whilst people's relatives were involved in the discussing people's care there was little evidence to suggest that the person themselves had been involved or, had their capacity to participate and consent assessed in accordance with the Mental Capacity Act. This aspect of service delivery required improvement. The third care file we looked at indicated that a mental capacity assessment was due to take place the following week in respect of the person's care.

People we spoke with told us they had a choice of what they would like to eat and drink when they stayed at the centre and that the food was good. One person told us that "There is a choice (of food) if I don't like what's on offer. I help myself to drinks when required". Another person said "I get enough food, if I don't I put them in their place about it. I like burger and chips and things like that".

Relatives we spoke with told us they believed people got enough to eat and drink. One relative said "They (the person) have put weight on. They tell me at Hall Lane that they have eaten and drank well on their visits".

Another relative said "They know what they (the person) likes food wise. I have eaten there on open days and things and it's always been fine. Well the staff eat the food themselves I presume, so they are going to make sure it's nice aren't they". A third relative also told us that their relative required a special diet and that staff had ensured that they "Had a healthy eating plan in place".

We observed the lunchtime period and saw that people's meals were served at times to suit them, For example, one person wasn't hungry at lunch and staff prepared their lunchtime meal later on, when they were ready for it. A staff member also told us that people could have a small lunch and a big tea or vice versa in accordance with their preferences. This was good practice and ensured mealtimes were person centred.

On our visit to the kitchen we saw that it was clean and tidy. Staff had information on people's dietary preferences or special dietary requirements and there were food stocks in both the fridge and freezers sufficient to feed the number of people who currently lived at the centre. We found however that information in relation to one person's nutritional needs was confusing.

This person required their meals to be specially prepared in liquid format. When we checked their care file however we found conflicting information about how much diet and fluids the person needed each day to maintain a healthy weight. This placed the person at risk of receiving an inappropriate and insufficient diet. We also found conflicting guidance for staff to follow when cleaning and maintaining the equipment they used to give the person their meals and drinks.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us staff treated them well and were kind. One person told us "Yes, I have a laugh and banter with them".

We observed staff throughout of visit. We found staff to be kind and patient with people when they required support but we found that agency staff providing one to one support did not always interact in any meaningful way with the people they were supporting outside of these times.

When we asked people if staff had the time to sit and chat with them, one person said "Sometimes, it depends how busy they are". Another said "There is not much in the facility. Staff are busy but I go to the local shops on my own". They went onto say that "Staff do a fantastic job. I can chat to (name of staff members). They are all understanding, when they are not too busy".

We saw examples where staff supported people in a dignified and respectful way. When people needed assistance with personal care or mobility, they did so discreetly without drawing unnecessary attention to them. When we chatted to staff about the people they cared for, we found them to have an understanding of people's needs and preferences. We found however that the management of the service required improvement in order for the service to be consistently caring.

For example when we looked at the staff communication book we saw that people's relatives had regularly reported that people's clothing or personal belongings were missing on their return home. Between March and August 2017, there were 12 entries made in the staff communication handbook stating that people's relatives had reported that some of the person's personal belongings had not been returned with them. It was unclear whether some of these reported items were found and returned to people as adequate documentation of these concerns and the outcome had not been made.

One relative also told us "Two weeks ago they (the person) came home in the wrong clothes. Thick men's socks, different trousers and t-shirt. None of their own. I phoned but have not heard about their clothes". This meant that this person's dignity was compromised.

We spoke to the manager about the issues associated with people's missing clothing and belongings. They were unable to provide a satisfactory explanation. They told us that sometimes items were lost when people attended the day centre but they were unable to explain why security arrangements for protecting people's personal belongings had not been put into place to mitigate this risk. This meant that no adequate action to ensure people's personal belongings were treated with respect had been taken.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

The relatives we spoke with told us that staff kept them informed of people's progress but we found that people who used the service and their relatives were not actively supported to express their views and be

involved in making decisions about the service overall. For example through resident and relatives meetings or annual surveys. This did not demonstrate that the service valued people's opinions and suggestions about the service and how it could improve.

Inadequate

Is the service responsive?

Our findings

People we spoke with told us that staff made them feel welcome when they came to stay and they were able to make their own choices. One person said "I can have a lie-in but because of my autism I like to have a routine. Staff ask me nicely if I lie in bed too long, I do need prompting to get up".

Most of the relatives told us that the people who came to stay, looked forward to and enjoyed their 'short break' or respite stay at the centre. One relative said "(Name of person) enjoys staying there" and another relative told us that "(Name of person) enjoys going to Hall Lane so much that they try to work out when their next visit will be".

One person's relative said ""They (the person) can't wait to go back in (to the centre). They have made friends and now have a social life. It's been a big boost to their confidence and they have really benefitted from it. It's been a really positive experience".

Staff we spoke with demonstrated a person centred attitude to providing people's care and we saw that the majority of staff interacted with people in a person centred way. One staff member told us that "Good communication is the key here. I like to make that difference to people's lives. Improving their independence first and foremost".

We viewed the care files of three people. Two of the care files we looked contained a person centred profile of each person. Each person's profile contained information about the person, their family, likes and dislikes, personal care preferences and the guidance on the best way to communicate with the person. This was good practice and gave staff an understanding of the person they were caring for.

One person's care file who, had come to stay at the centre at short notice contained little information about them as a person, their needs, risks or care. This made it difficult for staff to know how to care for the person in a person centred way. This was further complicated by the fact that the person's first language was not English. We spoke to the acting manager about this and they acknowledged that the information provided to staff was insufficient. When we returned to the service for the second day of the inspection, the acting manager had organised for an interpreter to visit the person with their family so that an accurate picture of their needs, wishes and preferences could be gained.

Records showed that people's needs and risks were sometimes reviewed but that these reviews were not consistent. For example, one person's risk assessment in relation to nutrition had not been reviewed since July 2016 despite the risk assessment stating it was to be reviewed "every six months or sooner" and another person's medication plan had not been reviewed since November 2016. This did not demonstrate that the service ensured the care they provided responded to the changing needs of the people it supported.

A staff member we spoke with told us the service undertook a yearly review of people's care with their family and a relative we spoke with confirmed this. There was limited evidence however of these reviews in the three care files we looked at and limited evidence that the people themselves had participated in this type

of care review.

We looked at people's daily care records and other records relating to the delivery of the service and saw that at times people's support was not provided in a person centred way to ensure their needs and risks were managed appropriately. For example, one person's relative reported that the person returned home covered in a skin rash after hand wash had been left in the person's room and they had unsupervised access to it. The relative told us "They smeared themselves from head to toe in it and they came out in red blotches". This relative also went onto to say that sometimes staff failed to understand the person's behaviours and this has affected the person's well-being. They said "There have been times when they (the person) has had behaviours. The staff have rung to say they are doing this and that but if the staff aren't understanding, it's difficult for (name of the person)".

When we looked at the provider's safeguarding and complaint records, we saw that two relatives had raised concerns about the care the person had received whist at the centre. Concerns were identified with the care the person had received with regards to personal hygiene, skin integrity and psychological well-being. The relatives had voiced concerns that care was not provided in a way that met the person's individual needs which had caused the person anxiety and distress. This did not demonstrate that person centred care was always provided.

One relative commented that "(name of person) clothes were filthy on the sleeve and on the sleeve". "They were very smelly like they had not been showered or washed because they had not even had a shave". They reported that "Name of person was very distressed when I picked the up on Sunday". The other relative reported similar concerns. The concerns of both relatives were investigated and found to have some merit. One person's relative asked for alternative respite provision to be found for the person following the incident.

We asked people and their relatives how they occupied their time at the centre. The majority of people we spoke with told us that for most of the time there was little to do. One person said "Really there's nothing to do in the building. Once a month they have a disco 6-8pm". Another person said "I like doing puzzles and jigsaws in my spare time. I like having something to do. I bring them in from home with me".

One relative told us "I don't think they get out much due to staffing cutbacks and the number of other residents they've got in. It's a shame because they took them (the person) to Blackpool once and they loved it".

A second relative said "They take them (the person) down to the day centre on the ground floor but generally speaking I'm not sure what they do with them". A third relative said "They (the person) go to the day centre each day".

We asked the acting manager about the activities on offer and were told people could access the day centre downstairs which had a range of activities. They told us there was no set timetable of activities or outings provided by the service itself at the moment. This meant that people who did not want to, or who were unable to attend the centre had little to occupy or interest them, other than the television. This did not demonstrate that the service planned for and ensured people had access to a suitable range of activities to prevent them from becoming socially isolated during their stay.

These incidences were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care was not always provided in a person centred way to ensure people's needs, wishes and preferences were met at all times.

We saw that the provider had a complaints procedure in place. The people and the relatives we spoke with told us they knew who to speak to if they had a concern about the service.

We found however that the system in place to receive, record, handle and respond to complaints was ineffective and inadequate. We found multiple instances in the staff communication book where relatives had phoned up to complain about people's missing belongings yet these concerns had not been properly documented, listened to or appropriately addressed. We found that the complaint system in place only listened to and acted upon people's complaints when they were formal for example, when written in a letter.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have an effective complaints system in place to ensure that people's complaints and concerns were investigated and acted upon where necessary.

Inadequate

Is the service well-led?

Our findings

The service was not well led.

The usual management team at Hall Lane Resource Centre consisted of a registered manager and two care co-ordinators who supported the registered manager in their managerial duties. When we inspected however, we found that the registered manager had been off work for approximately eight months prior to our inspection. One of the care co-ordinators had also been off work for a significant period of time. On the day of our inspection, the service was being managed by one care co-ordinator and an acting manager who covered the service approximately two days a week. We found these management arrangements to be inadequate.

On the first day we inspected we saw that the care co-ordinator was extremely busy, trying to do several different jobs at once. We spoke to the acting manager and other senior managers from the Local Authority about this. They acknowledged that the care co-ordinator was very busy but it was clear from our observations and discussions they had taken no effective action to address this.

We looked at the quality assurance systems in place to ensure people experienced safe and appropriate care. We found the provider's arrangements to be inadequate.

The provider had no effective system in place to ensure that sufficient information about people's needs and risks was gained prior to admission. This meant the provider had no way of knowing if the service was able to meet the person's needs prior to them coming to stay. We spoke to the acting manager about this. When we returned to the service a week later, the acting manager told us they had discussed with the commissioners of the service, social services and other external parties the need to have a minimum set of information on each person's needs and risks prior to admission. Whilst this was a start in the right direction, it should not have taken inspectors to raise concerns about this before any action was taken.

In two out of the three care files we looked at, information in respect of people's needs, risks and care was poor. We asked the manager if they audited people's care plans to ensure they provided accurate and up to date information for staff. They told us no specific care plan audits were undertaken. This meant there were no systems in place to ensure that staff had sufficient information to provide good care that met people's needs.

On the first day of the inspection, we asked for information on accident and incidents, safeguarding, complaints, training and audits to be provided. The acting manager had great difficulty in accessing the information we requested and providing it for regulatory purposes. So much so, that we had to call an end to the first day of the inspection without this information being provided. This meant we had to return to the service for a second day.

We found information in relation to accident and incidents, safeguarding matters, complaints and training were all reported centrally with no adequate analysis and feedback mechanisms in place to inform the local

management team at the centre where improvements were required. This meant that there were no adequate systems and processes in place to enable the acting manager or registered manager to assess, monitor and mitigate the risk of avoidable harm to people using the service, staff or visitors.

When we asked what audit systems the provider had in place, the acting manager provided us with a copy of an audit building tool. The audit building tool was to be used by different managers to audit each other's service every three months. We found the audit process to be a generic. The audit looked at the general environment, food stocks and storage, health action plans and medication but failed to provide sufficient detail of what had actually been checked. This meant it was difficult to tell what specific issues had been identified and what improvements were required. For example, it failed to specify whose health action plans and medication administration charts had been looked at or how many had been audited. This meant the audit was relatively meaningless.

We found there were no adequate governance systems in place to ensure staffing levels were sufficient and the system in place to plan staff rotas was ineffective. There was also no adequate monitoring system in place to ensure the staff employed had received the training they needed in order to meet people's needs.

There were no effective management arrangements in place to ensure people's social and activity needs were met and no adequate mechanisms for people and their relatives to feedback their views of the service. This meant the provider's governance arrangements failed to take into account people's experiences of the service so that they could gain an informed view of its quality and safety.

Provider of regulated service such as Hall Lane Resource Centre, are required by law to notify CQC of certain events which occur in the service. Records showed that the provider had failed to notify CQC of notifiable events.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have adequate governance arrangements in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service.