

Freeways

Kenneth House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

We carried out this inspection on 9 and 17 August 2016 and it was unannounced. When Kenneth House was last inspected in August 2013 there were no breaches of the legal requirements identified.

Kenneth House provides care and accommodation for up to eight people with learning disabilities. On the days of our inspection there were seven people living in the service.

There was a registered manager in place at the time of our inspection; 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.

On the second day of the inspection the registered manager was on annual leave. The home was represented by another of the provider's registered managers.

The provider's quality assurance systems and processes did not ensure that they were able to effectively assess and monitor the quality of the service and mitigate the risks relating to the health, safety and welfare of service users.

The provider did not have an effective system to monitor records made by staff or records that related to the management of the service.

The home was not suitably safe and clean. Hygiene practices within the laundry did not meet the Department of Health guidance for the prevention and detection of infection.

The administration of medicines was not in line with best practice.

There were not sufficient numbers of staff to support people safely. Staff refresher training was not up to date.

Staff did not have a good understanding of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS). The registered manager had made appropriate applications for DoLS where they had been required. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

We observed occasions where people's care and dignity were compromised. Some people were wearing torn and dirty clothes.

Care was not consistently person centred. Care plans did not contain unique individual information and

references to people's daily lives.

Meetings had been arranged in order to enable people's best interest to be assessed when it had been identified that they lacked the capacity to consent to their care and treatment. Records relating to capacity assessments and best interest decisions require improvement.

The provider had made appropriate arrangements to identify and respond to allegations of abuse. Staff were aware of the provider's safeguarding policy and how to respond to actual or suspected abuse to keep people safe.

Incidents and accidents were recorded and actions to prevent them reoccurring were recorded. Staff felt that their views and concerns would be listened to but were not confident these would be acted upon.

People were supported by the staff to use the local community facilities and had been supported to develop skills which promoted their independence.

People sustained good health by the means of nutritious food and sufficient drinks.

People had access to healthcare professionals when required, and records demonstrated the service had made referrals when there were concerns.

Staff supervisions were undertaken as planned to provide staff with support to carry out their work.

There was a complaints procedure for people, families and friends to use and compliments were also recorded.

There was a robust staff recruitment process in operation. The process was designed to employ staff that would have or be able to develop the skills to keep people safe and support individuals to meet their needs.

We found six breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not safe.

The home was not suitably safe, secure and clean.

Risk assessments and strategies to minimise risk relating to people's behaviour had not been completed for all people using the service.

The administration of people's medicines was not in line with best practice.

There were not enough staff to meet people's needs effectively.

Staff were trained in safeguarding adults.

The provider's recruitment procedures were effective in ensuring only suitable staff were employed at the home.

Is the service effective?

Requires Improvement ●

The service was not effective.

Staff did not demonstrate good knowledge of the legislation or the Mental Capacity Act 2005.

Training was not up to date. Staff received regular supervision.

DoLS applications had been made for those people that required them.

People were provided with nutritious food of their choice and sufficient drinks.

Is the service caring?

Requires Improvement ●

The service was not always caring.

We received positive feedback about the care and support that people received. However our observations showed that, at times, people's dignity was compromised.

People were given choices in their daily routines.

Is the service responsive?

The service was not responsive.

Sufficient action had not been taken to ensure people's care records were fully completed.

Care plans were not personalised and did not contain unique individual information and references to people's daily lives.

People were supported to use healthcare services.

There were systems in place to respond to complaints.

When staff were available people were supported in promoting their independence through activities and community involvement.

Requires Improvement ●

Is the service well-led?

The service was not well led.

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

Staff felt that their views and concerns would be listened to but were not confident they would be acted upon

The provider had failed to act on feedback to ensure that people and staff views were responded to.

Statutory notifications had been made to the Commission for notifiable incidents. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

Inadequate ●

Kenneth House

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.

The inspection took place on 9 and 17 August 2016. This was an unannounced inspection, and was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

Prior to the inspection, we viewed all information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke to five people who used the service, the registered manager and four members of staff. We tracked the care and support provided to people and reviewed three care plans. We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports. We also made observations of the care that people received.

Is the service safe?

Our findings

The premises were not secure and did not ensure that people were kept safe. We notified the registered manager of this on the day of inspection to ensure measures to keep people safe were put into place.

The home was not suitably clean. The general and communal areas of the home were dusty and carpets were not thoroughly clean. Skirting boards were dusty and that there were sticky marks and dust over furniture surfaces. There was also a stale musty odour on the second floor of the home which was present throughout both days of the inspection.

The registered manager told us that people living in the home were supported to clean their own bedrooms and staff cleaned the communal areas of the home. The level of cleanliness we observed in the home demonstrated that the cleaning undertaken was not thorough enough to maintain appropriate standards of cleanliness.

The garden was not well maintained or suitable for purpose. On the second day we visited it was warm and sunny outside. We were shown the garden by a person who lives in the home; we found that the garden was not a pleasant and accessible place for people. In the garden there was a large rotary clothes dryers placed directly next to seating. We were unable to sit down without the drying clothes blowing into our faces. This rendered the only available garden seating unusable. We also saw that an old sofa had been placed outside at the end of the garden with other rubbish. The surfaces were mainly paved in the garden with few areas for planting. Construction work next door had impinged on the garden; one third of the home's garden has been taken over and fenced in. This meant that there was little to stimulate the senses or provide a place to relax for people

These failings amounted to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The Department of Health (DH) publishes the Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance ("the Code"). The Code sets out the basic steps that are required to ensure the essential criteria for compliance with the cleanliness and infection control requirements under the Health and Social Care Act 2008 and its associated regulations are being met.

The provider had not followed the DH code of practice on the prevention and control of infections. There was no infection control lead assigned for the home. The registered manager had been unaware of the requirement for a lead person to undertake responsibility for this area of care and the need for infection control audits. We found that audits had not been undertaken since September 2015. There were no alternative practices undertaken by the provider to demonstrate that infection control was being monitored. The provider had not ensured there were systems in place to assess the risk of infections to people using the service. The practices in place for infection control did not comply with the code of practice and guidance for the protection of people who use the service.

People were not supported in a hygienic environment. In one shower room and toilet we saw a shower chair which was unclean; it was covered in stains and had rusty feet. We also observed a towelled floor mat used around a toilet; this increased the risk of cross contamination between people.

The home did not have recognised procedures in place to handle laundry. We were told that an open laundry basket was used to transfer soiled linen to the laundry. The same basket was used to transfer clean linen back to the person. This presented a risk of cross contamination. There were also no clear segregation procedures and areas within the laundry room for processing the laundry. There was plaster peeling away from the walls, the floor was cluttered and dirty. The work surfaces and the sink had lime scale on and around it. There were dirty damp mops left head down on the floor which meant that bacteria could develop. Clean laundered items were stored next to items waiting to go into the washing machines and dirty items were stored in open laundry baskets. The laundry area increased the risk of cross contamination and the spread of airborne infections.

During the inspection we also identified a specific issue around the management of infection control practices for one person. These practices increased the risk of cross contamination within the home; they had not been risk assessed for infection control and were not managed in line with published guidance.

The home had completed an assessment of people's risks and had recorded guidance on how to manage identified risks. The risk assessments showed that assessments had been completed for areas such as behaviour. Behaviour that may be viewed as challenging had been identified and strategies to support people detailed. Guidance showed how to reassure and support the person to move away from the situation.

We found that although risk assessments were detailed and provided strategies on how to alleviate risk, not all risk assessments around people's behaviour had been put in place. One person had a longstanding behaviour which had occurred sporadically over a number of years. This behaviour placed the person and others at risk. This behaviour was known to the registered manager and to some of the staff. There was not however any risk assessment in place to manage this behaviour or any strategies to minimise risk to the person or to other people and staff.

Some of the staff we spoke with were unaware of this behaviour. They did not have full information to manage support to this person should this behaviour occur. The lack of risk assessment and strategies to help the person manage the behaviour meant that the service may have missed opportunities to apply measures to minimise or prevent this behaviour. We raised the lack of risk assessment and behavioural strategies as a serious concern with the registered manager.

We also saw that another person required regular monitoring of where they were on the premises in order to ensure their safety. We found that the risk assessments for this person did not provide any guidance for staff on the frequency or recording of monitoring the person. We observed that on the second day of inspection staff met for handover in a closed room with the door shut. The person was on the ground floor of the service and approached the inspector to assist them to the toilet. The inspector observed that whilst in the handover meeting there was no staff presence monitoring the whereabouts of the person or any of the people, the handover meeting took place for 15 minutes. The inspector interrupted the meeting to ask a member of staff to assist the person to the toilet. This meant that the service had failed to put measures in place to keep this person safe.

During the inspection we also looked at the arrangements for the storage, administration and disposal of medicines. There were medication profiles for each person that provided staff with guidance on their diagnosed medical conditions and the medicines that had been prescribed. We looked at the profiles and

found that some had not been updated since 2013. The medicines prescribed on these profiles did not necessarily match the current prescription. We also saw that photos used on these profiles to help staff recognise people to whom they were administering medicine were old. The photos had not been dated and did not always reflect the person's current appearance. In one example one person appeared more than a few years younger and had a full head of dark hair. When we met the person they had completely grey hair and did not resemble the photograph. There was a risk that staff who may not know people well may inadvertently administer the incorrect medicine to them.

There were no PRN (as required medicines) protocols in place for people. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of the specific situations when people may need these medicines because the PRN protocols were not available with the medicine administration record (MAR) it meant that staff who were unfamiliar with people's needs would not have the information required. The reason for administering PRN medicines was also not always documented. We also found when it had been documented staff had used the incorrect paperwork. This meant it was difficult for staff to identify any trends or common themes in relation to when the person required the medicine.

Dates were not always being recorded when topical creams and gels were opened, this meant there was a risk that once opened these medicines could pass their shelf life date and be ineffective or unsafe for use on people.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Only staff who had completed medication training administered medicines. The pharmacy provided printed MARs for staff to complete when they had given people their medicines. We looked at the MAR for three people. These had been completed appropriately and showed people had been given their medicines as prescribed. Additional information about the medicines was available for staff to help ensure that people were given these medicines correctly. People confirmed they were assisted with their medicines by the staff on duty.

Medicines were disposed of safely. We saw that medicines for disposal were kept in a locked cupboard before removal. The log book for this was signed by two staff members and was signed by the person removing items that were no longer required.

There were not sufficient numbers of staff to support people. The registered manager told us there were two staff on duty during the day and late shifts; between 7.45am and 10pm. The two staff during the day shift included the registered manager if they were on duty. There was also an additional member of staff on a mid-shift on days when there were keyworker meetings arranged. At night there was one sleeping member of staff on duty who was there in case of an emergency. The registered manager explained that some people's needs had increased and the need for additional one to one staffing and funding was under review with the placing authorities. There were no auxiliary staff; the care staff assisted with cooking and cleaning whilst undertaking their care role.

Shortfalls in care staff hours were covered by care staff or by the use of bank and agency staff. The registered manager explained that there was a heavy reliance on bank and agency staff. Some staff had recently left the service and the provider was recruiting for further staff. There was also an acting team leader vacancy which had been filled. However, the staff member was yet to take up the position. We looked at the last two weeks of staff rosters with the registered manager, we found there had been two occasions when the

staffing level had fallen below the provider's assessed staffing levels; there had only been one member of care staff on duty on two Sunday late shifts. The registered manager had been unable to cover the shortfall with bank or agency staff but felt that as none of the people required assistance to go out that this had been acceptable. This meant that where people required one to one care there would not be another member of staff on duty to assist other people.

The number of hours care staff were required had increased due to people's needs. On regular occasions one of the two care staff on duty was undertaking one to one care with one person either within the home or in the community. This meant that the other member of staff was required to remain in the home to assist other people and undertake other duties such as cleaning. This meant that there were regular occasions when there were not enough staff to accompany people to go out. Three people we spoke with stated that although they could go out independently, on occasion they wanted staff to accompany them for companionship or to assist them with transportation. One person explained that unless there was a trip planned, there usually wasn't anyone available to accompany them. Another person said "We don't have enough staff, we've lost a lot of them and we can't always go out if we need them to use the car, because they don't all drive."

Care staff we spoke with were concerned at the staffing level. One member of staff told us that some people did not understand why staff had left the service and required regular reassurance and more companionship than they would usually need. The registered manager also confirmed that there was anxiety amongst people with regard to the staffing situation and that some people's behaviour had been negatively affected. The registered manager explained that the staff who had left the service had been well-liked so their absence was felt by the people at the home. We also observed this and two people we spoke with told us that they were not happy as staff had left. Staff also said, "We're not really able to be person centred because there's not enough of us to give people enough one to one time that they need." Another member of staff said "We really need more one to one time with the residents, some of them are independent but for instance [person's name] likes someone to go out with them and we can't do that regularly."

We observed that staff were task orientated to complete what needed to be done and did not stop to spend much quality time with people, unless they were providing one to one care. Staff we spoke with described their roles in relation to tasks and described every morning and mealtimes as being particularly hectic. We also observed this on the first day of inspection.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents and accidents were recorded by the staff. There was a system to review reported incidents and accidents. This meant that the service was able to identify patterns or trends in incidents and accidents to assist preventing or reducing reoccurrence

The service had a policy and procedure regarding the safeguarding of people and guidance was available in the office area for staff to follow. Staff told us that they would report any issues of concern to the registered manager or the provider. Staff were aware of types and signs of possible abuse and their responsibility to report any concerns to senior staff or the registered manager. Staff also understood the term whistleblowing.

Staff files showed there was a safe and effective recruitment procedure in place. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment

process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role. We also saw evidence that people who use the service had been involved in recruiting new members of staff and were given the opportunity to interview prospective candidates. People were empowered to be actively involved in recruiting staff for the home.

People told us that they generally felt safe and cared for by staff.

Is the service effective?

Our findings

Staff received training provided from the provider when they joined as part of their induction programme; induction training was to be completed within the first six weeks of in their role. Induction training subjects included first aid training and fire procedures. We saw that in one staff members file, induction training subjects did not appear to be completed and the staff member had been in post for over six months. The provider had not assured that staff received the necessary induction to enable them to meet people's needs effectively.

There was a training programme in place which was monitored by the registered manager and the provider. All staff had to complete annual refresher training. Examples included safeguarding, manual handling, medication, first aid, deprivation of liberty safeguards and mental capacity. Staff we spoke with told us they had received the training programme. We reviewed current staff training matrix. We saw that staff received the training programme when they had joined the service however the annual refresher training was frequently out of date. Further to this, training records were not completely up to date. We found three different versions of a training matrix amongst the records for the service. This meant that it was difficult to ascertain which staff required training. For example the most up to date version of the training matrix showed that one member of staff had not received the annual fire training for over two and a half years and that another member of staff had not received safeguarding training for nearly three years.

Specialist training was available to enable the staff to meet people's specific support and health care needs. This training included supporting people with communication difficulties and managing challenging behaviour. The training matrix indicated that very few staff had undertaken the communication training. The managing challenging behaviour training had been completed by some staff, however the last recorded date of training was in 2013 and many of the current staff had not received the training. The provider had not ensured that staff were given training to enable them to meet people's specific support and care needs.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent was sought in line with legislation and guidance. Care plans recorded people's consent to care and support which where possible had been signed by people.

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's capacity to make decisions had been assessed. We saw examples of appropriate best interest decisions being made, such as in relation to access to computer technology. The service had invited appropriate people such as family members to be involved with best interest meetings which had been documented. We noted however that some capacity assessment and best interest decision records were recorded poorly. For example one capacity assessment was based around three decisions; it did not however break down each decision being discussed separately. The assessment also did not indicate that

the person was in agreement with a specific decision or any comments which reflected their agreement. We also saw a capacity assessment during the inspection where the decision to be made was 'missing' this was pointed out to the registered manager at the time.

We saw from the training records that staff had received training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with did not demonstrate a good knowledge of the legislation in relation to people living in the home

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. 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 (MCA). 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 were being met. People's capacity to make decisions had been assessed and appropriate DoLS applications had been made and authorised.

Staff said they had received performance supervision and the supervision records we looked at supported this. Supervision was expected six times a year by the provider. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The supervision records we looked at gave detailed feedback about performance, discussion of training and development needs. Although the registered manager had undertaken supervisions we could not be assured they were ensuring that staff performance and progress was monitored effectively as training was not up to date. Staff had an opportunity to voice their individual views. Staff we spoke with said "I've had a couple of supervisions. I find them useful, they give me a chance to give my opinion and I'm listened to. Though a lot of times we go over the same problems."

People were supported to maintain their well-being and good health. We saw from records that people had regularly accessed health care services. We saw that the service had supported people to maintain set appointments with healthcare professionals and effectively arranged emergency appointments. The staff had then acted upon the actions agreed at the respective appointments.

People were involved in planning how to meet their nutritional needs and were supported to have the food and drink of their choice. People told us they discussed with staff the meals they would like and the ingredients they needed to purchase. People told us that the menus for the home were agreed with them and staff worked with people to look at healthy eating options. One person said "If I don't like what's on the menu I can swop it for something else and I like to have a cooked breakfast on a Sunday." During the inspection we saw that staff provided assistance with preparing people's meals and encouraged people to make healthy eating choices.

We recommend that the provider follows best practice in relation to recording capacity assessments and best interest decisions.

Is the service caring?

Our findings

People's dignity and respect were not always protected. We observed several examples of people's dignity being compromised. Throughout our inspection we saw that some people had food debris around their mouth and other people were wearing soiled, dirty and torn clothing all day. The provider whilst supporting people's independence in undertaking their personal care had not ensured that people did not self-neglect their hygiene or appearance. We saw that people went out having neglected their hygiene and appearance; they had not been supported by staff to preserve their dignity whilst they were out in the community. We also observed that one person spent the majority of their morning with their clothing tucked inappropriately into their undergarment yet they were not supported to 'untuck' this garment for a number of hours. This did not demonstrate that people were always treated with dignity and respect.

These failings amounted to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were instances when the views of people was not always considered or recorded. For example the minutes of a staff meeting in May 2016 detailed discussions around healthy eating for people and introducing various ways of reducing unhealthy foods and sugar. One sentence read 'We spoke about using sweetener instead of sugar, especially when putting sugar on cereals and into hot drinks. Staff need to make sure sugar is locked away and the residents don't have access to shift keys.' The discussion around healthy eating recorded in these minutes did not demonstrate how people's consent would be sought to the various changes discussed and changes were recorded as being enforced through restricting access to unhealthy foods/sugar rather than seeking consent or considering each person's best interests where they lacked capacity. We were told by the provider that the registered manager had asked each person individually for their thoughts on this and that most people disagreed with the decision; therefore it was not implemented. There was not however a record of the conversations the registered manager had with people.

There was information available for people who were unable to communicate verbally. Pictorial boards were placed in the home to enable staff and other people to communicate with non-verbal people. We also saw that food menus were pictorial and there were pictorial boards to show who was present in the home (people and staff). People did however comment that communication between staff was sometimes lacking and records of requests were not always passed on. Staff told us that the number of recent staffing changes had led to some people's requests not being followed up if records of requests had not been made at the time.

We observed staff being kind and caring in their approach. Staff paid attention to people. Interactions were pleasant for example; we observed staff complimenting a person on their hairstyle and another member of staff complimenting another person on their sporting knowledge.

Staff were attentive in their approach when supporting people. We observed a member of staff asking a person if they would like to use the toilet. The person was agitated and the staff member discreetly assisted them to the toilet. We also observed a member of staff comforting a person who appeared upset, the staff

member was speaking very gently to the person and managed to calm them.

People who were able to communicate verbally told us they had been included or involved in their care planning. People said they had been asked for their views and opinions, while other people confirmed that they had been involved in decision making around their meals, holidays and activities.

People's privacy was maintained. All communication was polite. We observed that, where people preferred their bedroom door was closed. People had a key to their bedroom to help them maintain independence, in accordance with their wishes. People were observed locking their rooms before going out or into communal areas.

People told us they generally got on well together and were supported to develop relationships with each other; other people in the community and within the provider's other services. People told us about the friends they had made and events they went to with their friends. We also observed friendly interactions between staff and people which indicated a good relationship had developed between them. Generally throughout the day there was a warm and friendly atmosphere within the communal areas of the service. There were occasions when the behaviour of some people could have an impact on other people. We saw that the service had acknowledged this and put strategies into place to manage these incidents.

Is the service responsive?

Our findings

Care and treatment was not always planned and delivered in line with people's individual care plans. People had been involved in planning and producing their care plan and risk assessments, we found however this did not always happen as planned. People were meant to meet with their key worker once a month to discuss how their care was going and to plan for the forthcoming month. A key worker is a named member of staff that is responsible for coordinating the care and ensuring care documentation was up to date for an individual person. We found that keyworker monthly reviews had not taken place as planned. Key information relating to people's health, lifestyle and preferences had not been recorded accurately or updated when required. We saw for example that one person had a health action plan which was created in 2011 and last reviewed in May 2015; no changes had been made at this review. The provider had indicated that reviews of this document should take place every six months. When we looked at this document we found that the details relating to the person's activities such as attending college had changed. The contact details for the person's dentist, chiropodist and optician were all incorrect. The person had changed providers for all of these services. The plan did not correspond with their current needs. This meant that staff were relying on incorrect and outdated information to assist them to provide care to people. This put people at risk of receiving care which is inappropriate for their needs.

People also had a 'hospital passport' which contained essential information about them should they need to be admitted to hospital in an emergency. Some of the 'hospital passports' did not have relevant information about people's behaviour. This meant that the hospital would not be sufficiently informed of how to deal with the person's behaviour and provide a consistent coordinated response should the behaviour occur.

The quality of person centred information was not consistent within the care plans. Some of the plans were person centred and described in detail people's preferences in relation to all aspects of their care. However other care plans did not contain up to date information and were incomplete in relation to aspects of people's daily lives. In one person's care plan they had set a personal goal in May 2016. The section of the care plan which related to actions required to achieve that goal were incomplete, as was the date by which the goal was to be completed. We further noted that at follow up keyworker meetings the goal was not reviewed. This meant that staff did not have the relevant person centred information to assist them to support the person to achieve their goal. This type of information can be significant in an environment with people who have learning disabilities. The information can aid staff to provide care and support to people who have difficulty in communicating their needs. This is of particular relevance when new staff or agency staff are employed at the service. Accurate up-to-date person-centred plans would enhance their understanding of people.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to group activities, 1:1 sessions and activities they undertook with other members of the local community. Activities people undertook included attending football matches, undertaking car boot

sales, horse riding, pottery classes and, visiting a social clubs. One person said "I like to go out with [staff name] because we like the same things." Another person told us about a voluntary job they had and how staff were helping them to look for another to develop their life skills further. People also told us that they enjoyed going out for coffee and meals with staff, however, they had not been able to do this as much recently as there were not enough staff to go with them.

People told us about the holidays they had planned for the summer; some people were going to Devon for a holiday whilst other people had chosen to go on day trips of their choice. We saw that people had been assisted by staff to plan for these trips and were looking forward to their holidays.

People felt able to complain or raise issues within the home. The home had a complaints procedure available for people and their relatives. We viewed examples of complaints that had been addressed by the provider and registered manager, and saw that the concerns had been responded to. People we spoke with told us when they had reason to complain the registered manager had dealt with the complaint well. One person said "I would tell the staff or [registered manager's name]."

People were able to maintain relationships with friends and family. People said that friends and family could visit and told us about evenings when they had also visited their friends.

Is the service well-led?

Our findings

The provider had not demonstrated good leadership in respect of the support provided to the registered manager. During the inspection it was clear that on a number of occasions the registered manager was unaware of all of the responsibilities associated with their role. We asked the registered manager how they were mentored by the provider to understand what was required of them. We were told by the registered manager they had spent a month shadowing the previous registered manager. They had not been made aware of all of the responsibilities of their role as highlighted to them during the inspection. For example the registered manager was unaware of the need for infection control audits. We found that the registered manager had not received support from the provider that was commensurate to the registered manager's level of experience. The registered manager was also rostered to provide care and also act as a driver for people's transportation. This meant that the registered manager had little protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. The provider had failed to provide sufficient time, structured support and training to enable the registered manager to undertake their role effectively and to a good standard.

There were systems in place within the home to monitor quality and safety, however these had not been fully effective in ensuring consistent and good quality care was delivered throughout the service. We saw records of quality audits completed by the registered manager and provider which included areas monitored such as training and medicines. Their systems had failed to identify and adequately action the shortfalls found at this inspection. This included concerns surrounding; cleanliness; security; the accuracy of person-centred information; the lack of detailed staff instructions to assist people with their care and welfare and arrangements in place to safely manage medicines. For example there was a governance system in operation to monitor medicines. We saw that when this system was used, staff recording errors were identified and this message was conveyed to staff. However, we found that the system had not picked up incorrect paperwork being used to record PRN medicine, or the issues we found around undated creams and gels and out of date medicine profiles.

The provider did not have had an effective system to monitor the quality of people's care records and ensure the service held current and accurate records about people. We found that the provider had altered the system of quality assurance from bi-monthly provider visits, to self-assessment by the registered manager which was checked by a peer and a senior manager over a twelve week period. These quality assurance systems had picked up on various issues around the training records, staffing levels, and care plan records. We found however that the last self-assessment in June 2016 recorded that records for people such as health action plans were current; we found however they were not. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

The provider's quality assurance processes had not ensured that the premises and equipment used by the service were safe for their intended purpose. For example we saw that a fire risk assessment had not been undertaken since January 2014. A fire risk assessment was required annually. These types of issues were not picked up during quality audits.

The provider had sought feedback from people and staff for the purposes of continually evaluating and improving the home. We found however that the provider had failed to act on the feedback provided. Residents meetings were held every month. These meetings were held to provide people with an opportunity to discuss their goals, concerns and raise issues. However, we found that there were no action plans to follow up on actions raised during these meetings and the meeting minutes did not clarify if actions had been completed from the previous meeting. This meant that the provider missed opportunities to provide updates to people and ensure that actions that were important to people were completed.

We also looked at the minutes of staff meetings which were held monthly. We found that they also did not have action plans or always follow up on actions from previous meetings. Staff told us that the registered manager and provider would listen to their views and that they felt able to raise concerns or issues. However this did not necessarily mean their views would be taken into account. For example, one member of staff said "The [registered manager] has good intentions but we have problems with staffing and staff changes and communication is also not so good. These things don't change."

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A service user survey was last undertaken in April 2015; we found that there were no action plans available to follow up from this survey. We found that the last relative's survey had been undertaken in January 2015; an action plan was created to respond to relatives concerns. We were told by the registered manager that another relatives' survey had been due to be sent in April 2016 and that this was running late and would be sent in July and August 2016.

The provider had also introduced the 'happy app' to gain feedback from people. The 'happy app' is an online feedback tool which people are supported to use through the use of a computer tablet. This app was introduced to help gain feedback from people about how they felt about the service positive or negative; without the connotations attached to making a complaint as some people found this daunting. Each feedback report required the registered manager to offer actions to remedy negative comments or offer explanations to the person if required. People were asked to respond to the registered manager's actions to check whether they met with their satisfaction. The information was collated and the provider produced a report every three months showing various statistics for complaints, compliments and the number of feedback forms completed. Complaints were split into various topic areas such as staff behaviour and environment and this information was to be used by the service to assess areas where they could improve. The service was making use of this app. However, this was a fairly new process and engaging people and staff to use the app was still a work in progress.

People we spoke with gave positive feedback about the registered manager. One person said "I think he's trained and I don't mind him at all. Another person said "I like [registered manager] I can ask him anything."

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the registered manager had made appropriate notifications.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always planned and delivered in line with people's individual care plans. Regulation 9 of HSCA 2008 (RA) Regulations 2014
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect were not always protected. Regulation 10 HSCA 2008 (RA) Regulations 2014
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not followed the DH code of practice on the prevention and control of infections. Regulation 12 (1) (2) (h) HSCA 2008 (RA) Regulations 2014 Risk assessments and strategies to minimise risk relating to people's behaviour had not been completed for all people using the service. Regulation 12 (1) (2) (a) HSCA 2008 (RA) Regulations 2014 The administration of people's medicines was not in line with best practice. Regulation 12 (1) (2) (g) HSCA 2008 (RA)

Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The premises were not secure and did not ensure that people were kept safe. Regulation 15 (1) (b) HSCA 2008 (RA) Regulations 2014</p> <p>The home was not suitably clean. Regulation 15 (1) (a) HSCA 2008 (RA) Regulations 2014</p> <p>The garden was not well maintained or suitable for purpose. Regulation 15 (1) (c) (e) HSCA 2008 (RA) Regulations 2014</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There were not enough staff to meet people's needs promptly. Regulation 18 (1) HSCA 2008 (RA) Regulations 2014</p> <p>The provider had not ensured that staff were given training to enable them to meet people's support and care needs. Regulation 18 (2) (a) HSCA 2008 (RA) Regulations 2014</p>

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not demonstrated good leadership in respect of the support provided to the registered manager.</p> <p>The systems in place within the home to monitor quality and safety, the premises and equipment and people's care records had not been fully effective</p> <p>The provider had failed to act on feedback for the purposes of continually evaluating and improving the home.</p> <p>Regulation 17 (1) (2) (a) (b) (c) HSCA 2008 (RA) Regulations 2014</p>

The enforcement action we took:

Warning Notice