Integra Care Homes Limited

Delrose

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 12 and 16 April 2018. We gave the provider notice of our intention to visit so that they could prepare people with complex needs whose routines might be disrupted by our inspection process.

At our last inspection in April 2017 we rated Delrose as good. However we had received information of concern which prompted us to return ahead of the next scheduled inspection. This was a comprehensive inspection which looked at all areas of the service. We identified breaches of four regulations and found areas for improvement in all key areas. You can see what action we have told the provider to take at the end of the full version of this report.

Delrose provides residential care and support to a maximum of nine people who may be living with a learning disability, autism, or have mental health needs. The service occupies a large converted residential home near to local shops and other services.

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

Since the provider registered to carry on a regulated activity at Delrose, we have published guidance called "Registering the Right Support" for services for people with a learning disability or autism. The values which underpin "Registering the Right Support" include choice, promotion of independence and inclusion. People with a learning disability or autism using the service can live as ordinary a life as any citizen.

Although Delrose is close to local community facilities, its location on a busy main road introduced risks to the safety of people with very complex needs, which the provider found difficult to manage in a way that allowed people to access the community as freely as any citizen. There were people living at Delrose whose family did not live nearby which meant the service was not meeting an entirely local need for this type of service, and the provider had experienced recent difficulties in recruiting suitable staff from the local community.

There was a registered manager in post who was also the provider's area manager. A registered manager is a person who has registered with us 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.

The provider's system of risk identification and risk assessment was not always interlocked with the support planning process which meant people were not fully protected against risks to their safety and welfare. The provider had not made sure people were supported by staff with sufficient knowledge and experience to support them safely. The provider's process to review and learn from accidents and incidents was not

always followed.

The provider had not managed the induction of new staff effectively which meant people were supported by staff whose competence to support them had not been signed off. Staff were not supported to deliver high standards of care and support because the provider did not make sure there were timely supervisions in line with the provider's own policy.

People did not always receive care and support that met their needs and reflected their preferences. The provider's governance processes were not operated effectively to identify where the service failed to meet the fundamental standards that people should be able to expect.

The provider had processes in place to manage and administer people's medicines safely. The home was well maintained and kept clean. There were arrangements to protect people from the risk of the spread of infection.

Staff supported people to eat and drink enough and advised them on keeping to a healthy diet while respecting their right to make choices about their diet. Staff were mindful of the need to seek people's consent to care and support. Where people lacked capacity to make decisions about their care and support the provider complied with legal requirements to assess their capacity and make decisions in their best interests.

More experienced staff had established caring relationships with people using the service, but less experienced staff lacked confidence to do so. People's dignity was not always promoted and respected in the language used to record their support.

The provider engaged with people and their families. Informal and formal complaints were followed up. Although the provider's governance system had not prevented a decline in standards, there was a comprehensive improvement plan in progress to restore them.

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 always safe.

People were not always protected against risks to their safety and welfare.

People were not always supported by staff with the right knowledge and experience.

People did not benefit from improvements based on learning from accidents and other incidents.

People were protected against risks associated with medicines and the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff whose competence had been signed off at the end of their induction. Staff supervisions were not carried out to the provider's own standard of frequency.

People were supported to eat and drink enough. Care and support was only carried out with people's consent or in their best interests in line with legal requirements. People did not always receive planned healthcare services if they were seen to withdraw their consent.

People lived in an environment where there had been some adaptations to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff with a range of experience and knowledge. They had developed caring relationships with the more experienced staff, but not with the newer staff.

People's dignity and independence were not always promoted in

the way staff wrote about their support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support that was in line with their needs and preferences as recorded in their support plans and assessments.

When people or their families complained, their complaints were dealt with professionally.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management and governance of the service had not identified concerns and failures to meet fundamental standards in a timely fashion.

There was a detailed improvement plan in place, although this was still in progress and improvements had yet to be shown to be sustainable and embedded.

Delrose

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 was prompted in part by notification of an incident witnessed by individuals not involved with the service. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk relating to the safety of people using the service and the culture of the service. This inspection examined those risks.

This inspection took place on 12 and 16 April 2018. We gave the service 48 hours' notice of our visit to take into account the complex needs of people using the service and to avoid our visit clashing with the visit of other agencies monitoring the safety of people.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the minutes of local authority safeguarding meetings and information sent by representatives of commissioning authorities, and information sent to us by a person using the service.

As this inspection was brought forward due to concerns raised since the last inspection, the provider had not been requested so submit an up to date Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We were not able to speak directly with people using the service to understand their experience of the service as most had complex needs including communication needs. One person who was able to

communicate verbally declined to speak with us. We obtained information about the service from written records and social care professionals working for commissioning local authorities. We observed care and support in the shared area of the home.

We spoke with the registered manager, the regional quality manager and three members of staff.

We looked at the support plans and associated care records of four people including support records, behaviour charts and reference files. We reviewed other records, including the provider's policies and procedures, internal checks and audits, the provider's quality improvement action plan, and training and supervision records. Other records included medicine administration records, mental capacity assessments, Deprivation of Liberty Safeguards applications and authorisations, and recruitment records for four staff members. We reviewed the accident and incidents file. Following our visit, the registered manager sent us updated copies of the quality improvement plan, their registered manager's workbook and an updated internal audit report.

Requires Improvement

Is the service safe?

Our findings

The provider had a thorough and wide-ranging risk screening process for people's individual risks, but this was not always followed and did not always lead to appropriate guidance for staff in people's support plans. In one person's case, the statement of risk and guidance under "Communication" were general and did not contain enough detail for staff to manage the risk. For example, "[Name] is at risk of harming himself or others through uninformed / unhealthy choices, staff will support [Name] around certain situations and possible outcomes." In the same person's support plan around access to the community, there were actions for staff to avoid and manage risks around road safety. However, there were no actions to avoid or manage the identified risk of "jumping from a moving vehicle"

Another person's risk assessment for swimming was incomplete. The risk assessment had not been signed, the risk had not been evaluated, there was no date for review, and no record of the risk being reviewed since October 2016. The same person's risk screening had identified risks around bathing, and stated the person should have one to one support when bathing. This was not explicit in their support plan which stated in general terms, "[Name] will have 1:1 support during the day within the service, and for the settling in period [Name] will have 1:1 during the night". An undated and unsigned handover sheet stated, "He has a bath independently". The registered manager told us it was unlikely the person would have taken a bath without one to one support, but the risk records did not demonstrate that the identified actions were in place to keep the person safe.

A third person, who had a diagnosis of epilepsy, had been identified as being at risk while bathing. The provider's risk screening process required a specific risk assessment in these circumstances but this had not been done. There was a "bathing protocol" in their support plan but the process linking the risk identification and support plan was missing. The same person had a risk assessment for access to the community which specified two to one support outside the home. However elsewhere in their support plan it stated, "If a two person escort is used while I am in the community then an incident form will be completed upon my return."

These people were at risk of unsafe or inappropriate support because the risk assessments were unclear, inconsistent or incomplete. The provider had recognised a review of risk assessments was needed, and had included this in their quality improvement plan. However it was not clear that actions to identify and put right individual concerns had been effective. The most recent update of the quality improvement plan stated that all except one set of risk assessments had been "reviewed, updated and signed off". However there was still an outstanding action to carry out "a final check to ensure all risks have been identified and this matches the support plans".

Following concerns raised by visiting professionals, the provider had recently reviewed and republished their protocol for admitting visitors to the premises. Staff had signed that they had read the new protocol, but professionals still found the protocol was not always followed. On the first day of our inspection staff checked our ID cards before letting us into the home. However on the second day we arrived to find the door open and unattended. Staff did not always follow the protocol designed to keep people safe.

The provider had a process in place to learn lessons and make improvements when things went wrong, but this was not always followed. Staff recorded accidents and incidents, but the second part of the process was not always completed and actions to improve people's safety were not identified or recorded. Out of eight reports, five were incomplete and did not show that lessons were considered following the incident.

Failure to make sure care and support were provided to people in a safe manner was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always make sure staff deployed to support people had the necessary skills and experience. The service had experienced high rates of staff turnover, and had not been able to recruit equally experienced staff to replace those that left. One person's social worker told us only the more experienced staff had an adequate understanding of the person's complex needs, and the majority of staff were not experienced in mental health.

At the time of our inspection the provider was actively recruiting and the registered manager told us they had identified a number of more experienced, qualified staff. However these recruits were still going through routine pre-employment checks. Records did not show that the provider followed a robust recruitment process in carrying out these checks. One staff member's reference from a previous employer showed there had been a gap of three months' absence which had not been explained or followed up. Another reference stated "no comment" in response to a question about the employee's suitability to work with people made vulnerable by their circumstances. This had not been followed up. A third staff file contained no references. The registered manager was able to find the references online. However the provider's own processes for recruitment had not been rigorously followed, and the provider could not be certain people employed were suitable to work in a care setting.

In the meantime the service was dependent on agency staff and inexperienced employed staff to provide the staffing levels required to keep people safe. There was a risk that agency staff would be less familiar with people using the service. This meant the provider could not always have the required balance of expertise and experience on duty. A recent night shift had been staffed by four care workers all of whom had less than a year's experience at the home. One of them was still in their three month probationary period. The other three had not had formal sign off of their probationary period in a one to one supervision meeting. In two cases this was four months late at the time of our inspection, and in the third case it was seven months late. Three out of four staff files were missing significant records. One had no induction, training, probation or supervision records. A second had no induction, training or probation records, and a third had no induction or probation records. This meant the provider could not be certain people were supported by staff with the necessary skills, knowledge and experience.

Failure to make sure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to support people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other arrangements to protect people against risks to their welfare were in place. For example, there were risk assessments for using a barbecue in the garden and for a person who chose to smoke. These were designed to protect the safety and welfare of people using the service and others. Personal emergency evacuation plans were in place which showed how much support people would need to get to safety in an emergency.

Processes and staff training were in place to protect people against the risks of abuse. The provider had a whistle blower policy and information about a whistle blower helpline was clearly available to staff. Staff

were aware of their legal protection if they raised a concern about people's safety. All staff had received a recent refresher course in safeguarding adults in the month before our inspection.

The provider notified us and other agencies if concerns were raised. The registered manager was aware of their responsibilities with respect to the reporting and follow up of safeguarding concerns. They told us there had been one occasion when a report into a safeguarding concern had not been returned to the requesting local authority in a timely fashion. The staff member involved in this investigation no longer worked for the provider.

People were supported to receive their medicines safely. Medicines were stored securely and arrangements were in place for the administering and recording of medicines. Published NHS patient information about specific medicines was available to staff. People's care files showed their consent had been sought for staff to administer their medicines. These records had been reviewed recently in the month before our inspection. Medicines administration records were completed, and records were kept of medicines signed out if people needed them during a planned absence from the home. Where people were prescribed medicines to be taken "as required", appropriate protocols were in place for staff to follow. Staff carried out weekly stock checks of medicines stored in the home, and there were monthly audits of compliance with the provider's processes for medicines.

People were supported to live in premises which were kept clean and arrangements were in place to manage the risk of the spread of infection. Shared areas of the home and people's rooms were clean. Staff were aware of areas which might need more frequent cleaning, such as an area outside where a person preferred to smoke. Staff training included modules on food hygiene and infection control. The most recent environmental health check on food hygiene had given the highest score of five, "very good".

Requires Improvement

Is the service effective?

Our findings

The provider did not support staff by means of regular supervisions to obtain and maintain the necessary skills and knowledge to support people effectively. The provider had recognised this in their quality improvement plan, but actions to bring the frequency of supervisions into line with the provider's own policy were ongoing. The registered manager's workbook showed seven out of 25 staff had received a recent supervision. The workbook also showed three staff were overdue their annual appraisal. Three staff members had gone seven to eight months without a supervision when the provider's policy required them every three months. Records of supervisions which had been carried out before January 2018 were not available. The staff member involved in these no longer worked for the provider. We could therefore not be certain supervisions were used effectively to assess the effectiveness of training and to identify staff training needs.

The provider had a programme of refresher training for staff which covered basic aspects of care and support such as fire awareness, first aid, health and safety, manual handling, mental capacity, and "level one" medicines knowledge. There was a system in place to check staff were up to date with these refresher courses which showed 95% to 100% compliance. Training was also available in techniques to support people who might show behaviours that staff find challenging. This included understanding and recognising cues to these behaviours, positive behaviour support, communication, calming techniques and physical interventions, and was tailored to people's individual needs and presentations. However the provider's quality improvement plan had identified at least eight staff members who had not received this training. The provider had taken steps to book this required training, but the courses had not been delivered at the time of our inspection. There was a risk people would receive inappropriate support because of gaps in staff knowledge.

The induction process for new staff was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Training records showed that of 17 staff who had started the Care Certificate induction, three had completed it, five were in progress, and nine were overdue. This meant they had not been signed off as having completed the induction in the 12 week induction period. Records of progress for these staff members were not available as staff kept their own induction records until final sign-off. This meant the provider could not demonstrate people were always supported by staff with the necessary basic skills and knowledge.

Failure to make sure staff received appropriate training and support, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and support were based on thorough assessments which included a personal profile, choice and control, health and wellbeing, and everyday tasks. Assessments also took into account living safely and taking risks, family and relationships, managing money, community life and behaviours that might be found challenging.

Staff supported people to eat and drink enough. Staff advised people on a healthy diet while respecting they had the right to make their own choices about what they ate and drank. The provider's quality improvement plan included actions to improve this area of people's support. There was an action to have a focused team meeting on nutrition and hydration which was still to be carried out at the time of our inspection. There were also actions to improve the nutrition and hydration of an individual person. These were marked as completed, but the person involved was no longer living at Delrose.

People's support plans showed the service was aware of people's healthcare needs and where these could be met by engaging with other providers. The provider did not always have an effective strategy where people declined planned healthcare appointments or presented behaviours which made it difficult to attend appointments. One person, for example, regularly declined to attend health checks which had been arranged in their best interests. Health and social care professionals engaged with the service had identified support which was available in such circumstances, and the provider had expressed an interest in following up these offers so that people received the healthcare support they needed.

People living at Delrose had recently had eye tests with a visiting optician. One person was encouraged by staff to wear their prescription spectacles which made a significant difference to their wellbeing. Another person was encouraged to have a haircut which was a difficult thing for them as the normal strategy for calming them in unfamiliar situations was to give them a head massage.

Staff at Delrose worked with staff at other nearby homes in the provider's portfolio to enable people to participate in activities they enjoyed. An example of this was joint trips to a swimming pool, which meant people could take part in an enjoyable and healthy activity.

The building had been converted for use as a care home in 2015. On the ground and first floor of the home rooms were arranged off a long corridor with a hard floor. There were few soft furnishings in the corridors and shared areas of the home which meant they were noisy and had an institutional appearance. People had been able to decorate their own rooms to reflect their own preferences. One person whose goal was to live in a service which offered more independence had the use of an unused bedroom as a sitting room which meant they had a small suite of rooms rather than a single bedroom.

The provider had made some adaptations to the building and garden in the interests of people's safety. The front door which opened on a small car park leading to a main road was no longer in use, and the main access to the home was via a side door, which was safer. Fencing had been used in the enclosed garden to prevent access to a part of the garden which was higher and could be a falls risk.

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

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

Records were in place to show the provider complied with the Act and followed a correct process where people did not have capacity to make their own decisions. Capacity assessments were for individual

decisions, and where the person was found to lack capacity they were followed by properly documented best interests decisions. In one case the outcome of the assessment was that the person did not lack capacity and was able to make their own decisions.

Where authorisations were granted to deprive a person of their liberty, the provider had taken some steps to comply with conditions imposed by the supervising authority. A condition to facilitate face to face contact with the person's family had proved difficult to arrange, but the provider had made use of video calls as a substitute. Another condition required "urgent contact with mental health services" and access to an independent mental capacity advocate (IMCA). An IMCA is an advocate who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them. IMCAs do not make decisions and they are independent of the people who do make the decisions. Staff told us there had been one visit by an IMCA and a "couple of visits" by the community mental health team.

Requires Improvement

Is the service caring?

Our findings

There was a mixed picture as to whether the service involved and treated people with compassion, kindness, dignity and respect. The registered manager and senior staff spoke about people in a way that showed they knew people, their needs and preferences well. However the less experienced staff appeared to have less self- confidence around demonstrating kindness and compassion, and providing emotional support to people. We saw staff watching and supervising people without interacting with them.

The registered manager told us during recent recruitment they had not had applications from candidates with experience of supporting people with a learning disability or living with autism. They had tended to employ younger, less experienced applicants who lacked not only experience in adult social care but also did not have a depth of life experience to draw on when establishing relationships with people.

The registered manager had recently taken over direct responsibility for allocating and deploying staff. They now took more account of staff members' strengths and abilities and people's preferences when allocating staff for one to one support. This meant there was more opportunity for people and staff to develop caring relationships. The registered manager told us there was the potential to have a "good team" and that the atmosphere in the home was better, "nice and calm", now that more attention was paid to people's preferences.

Where people were able to communicate their views the provider supported them to take part in decisions about their care and support, although it was not possible always to give them what they wanted. One person was encouraged to write down their concerns so they could discuss them calmly with the registered manager.

Where people were not able to communicate their views, the provider involved their families, social services and other advocates. Social care professionals told us the provider cooperated, especially when the difficult decision had been made that the service was no longer appropriate to the person's needs. In one case a person's family wanted the person to move to be closer to a college which offered courses which were a better fit for the person's ambitions. Staff supported people to investigate and review other services where their needs would be met.

None of the people living at Delrose at the time of our inspection had particular needs arising from their religious or cultural background. However, the provider's quality improvement plan had identified that staff should have refresher training in equality and diversity, and in ethics and values. Most staff had received the equality and diversity training with three staff members outstanding at the time of our inspection. However the ethics and values training had been requested but not delivered.

The language used by some staff in writing up people's support records did not always show that people's dignity was respected. Records were not always written in a style appropriate for adults. One person's record stated, "[Name] was very well behaved today." Another referred to a person "occasionally shouting just to get attention".

Support records contained a section for staff to record if the person "did something special today". These did not always reflect that the person supported was an adult, and were often repetitive with the same "special" event recorded on several days. Examples were: "I paid for my shopping", "I had chips for lunch" and "Played with his sock". There were occasions when a small event did represent a genuine achievement for the person, such as wearing their spectacles for the first time, but the repeated recording of minor events did not show that people were genuinely supported to be as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive individual care and support which met their needs according to their support plans and assessments. One person's support plan stated it was important to follow a regular routine in the home since they no longer attended a day service. There was a detailed timetable in the staff office which showed the activities they should be involved in at specific times of every day of the week. During our visits we did not see that this routine was followed, which was backed up by support records. The routine included a car drive outside the home every day, three baths a day and sessions with "toys and games". In one week there had been no car drive on four days out of seven, no bath on three days, one bath on three days and two baths on one day, and two days when there were no toys and games sessions. This person's support did not follow the regular routine which had been devised to meet their needs. This meant they were at risk of presenting behaviours staff might find difficult to manage.

Another person had come to Delrose as an emergency placement in September 2017. Their support plan was based on information from their previous service, and had been reviewed in December 2017 and March 2018. It stated they should access the community at least once a day to take part in physical activities such as horse riding or cycling. Their support records for February 2018 showed they had left the home on seven occasions to "go for a drive". The registered manager said this was because they routinely declined other activities. However there were no records to show activities had been arranged, planned or offered in line with their support plan.

A third person's support plans were inconsistent. Their positive behaviour support plan reviewed in December 2015 stated "Due to a lack of incidents of behaviours that challenge… it has not been deemed necessary to put a behaviour support plan (BSP) in place at this time." However there was an undated positive behaviour support plan physical intervention list "for trained staff only" and a physical intervention protocol dated January 2017 and signed off by staff in March 2017. This stated, "Staff must ensure they follow the guidelines set out in [Name's] BSP" and "Please refer to BSP for complete instructions and guidelines." There was a list of staff who had been trained to use physical interventions, but it was not clear whether such interventions were part of the person's support plan and insufficient guidance if they were. This person was at risk of inappropriate care and support.

Support plans and records were structured and designed to record detailed information about people's care and support but they were not always used as intended by the provider. None of the support records we saw had the "Things I plan to do" section completed. This indicated there was insufficient planning or proactive thought about how to support people according to their plans to attain their goals. There were updates to one person's support plan which were not signed or dated, which meant it was not clear if the staff guidance was still valid. Another person's positive behaviour support plan had no date or signature. The registered manager told us this had been drawn up in cooperation with the person's mental health nurse, but this was not clear from the records. People were at risk of inappropriate care and support because these records did not show clearly when they were a
pproved as being valid.

Failure to provide care and support that was appropriate, met people's needs and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had introduced a key worker system which meant people and their families had a named contact on the staff for any questions or concerns. The key workers had started to write reports about people's care to share with families who might not live close to the home. These included a general overview, events, activities and wishes, relationship with staff and other residents, medicines compliance, incidents, behaviours, complaints, health appointments and needs. This meant there would be a regular review of people's care and support.

People had communication care plans which took into account various strategies used by staff to understand people. These included the use of pictures and signs. Staff used a recognised sign system and also signs unique to the person. With one person staff had started to use "objects of reference", a system where objects were used to represent an activity, person or place.

The provider had a complaints process which was shared with people's families when people moved into Delrose. The process was not available in an easy to read or picture based format, which might assist people to understand the process with support from staff.

One person was able to understand the complaints process and the registered manager received frequent letters from them. These were discussed with the person outside the formal complaints process because all parties agreed the underlying concern was that the person did not believe Delrose was the correct service to meet their needs. Their goal was to move to a service where they could have greater independence. There were discussions ongoing with their social worker about how to achieve this.

There were four recent formal complaints on file, three of which concerned a person who no longer lived at Delrose. All had been dealt with professionally and there had been feedback to the person making the complaint.

Requires Improvement

Is the service well-led?

Our findings

There had been a period where the provider had not made sure there was a robust and effective governance system at Delrose. The registered manager shared the role with that of area manager which meant they had responsibility for the provider's other homes in the area. The deputy manager at Delrose left the service in December 2017. Following an incident in January 2018 the registered manager had discovered actions reported previously as complete had not actually been done. Certain records to do with the management of the service and people employed were missing. These included an enquiry into a safeguarding concern requested by the local authority and requests for authorisation under the Deprivation of Liberty Safeguards. Records relating to staff supervisions were not available.

Unusually high staff turnover had revealed that the provider's recruitment processes did not always make sure they employed staff suitable to work with people with complex needs. The registered manager told us they had not received applications from people with more experience which had resulted in a staff team lacking in experience and confidence. They pointed out that a request to increase the hourly rate for care staff to try and attract more experienced staff had been rejected by the provider. The combination of an inexperienced staff team and ineffective supervision and governance had resulted in standards not being maintained. Inexperienced staff had been demotivated by the investigations put in place following the incident in January 2018 and did not feel safe in their jobs.

The provider had systems in place to monitor, assess and improve the quality of the service provided. However these had not been operated effectively and had not led to actions to prevent or resolve issues identified by the provider and discovered in our inspection.

Failure to operate effective systems to make sure the service complied with the fundamental standards established in regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the incident in January there had been three visits to the home by the provider's quality team and line management. The provider had developed a quality improvement plan with 60 individual actions. This was monitored by the registered manager and by the regional quality manager. Some actions were shown as completed, but others were still in progress. According to the provider's own quality audits, compliance with the provider's own standards had improved from 61% to 79%. There had not been time for the improvements put in place to be fully embedded in practice and for the provider to demonstrate they would be maintained and sustained.

The registered manager's ambition for the service was to establish a stable and well trained staff team, to enhance people's day to day experience and to keep improving. There were plans and actions in place to recruit support and management staff to achieve this. The registered manager told us more recent recruitment drives had resulted in more experienced candidates applying than had been the case previously. They were optimistic they would be able to reduce their dependence on agency staff when these applications were all processed.

Arrangements were in place to engage with people's family and other advocates. The registered manager spoke with people's families on a weekly basis. Key worker reports had been established which gave a monthly written status of people's care and support for families. All the people living at Delrose had had a service review by their commissioning authority since January 2018.The registered manager told us actions arising from these had been completed.

There were concerns around how the provider managed medicines, blood tests and other healthcare interventions when people declined these services. Commissioning authorities had suggested to the provider local services which could work with them to improve people's experience in this area.

The service reviews had also concluded that for some people other services might be better able to meet people's needs. The provider was cooperating with the commissioners' processes to research and identify alternative placements for people where this was considered the best option for them.

The registered manager had a network to keep their own skills and knowledge up to date. This included the provider's wider organisation where expertise and learning could be shared with peer managers, and a local charity which supported people caring for people living with autism.

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 Service users did not receive care and support that was appropriate, met their needs, and reflected their preferences. Regulation 9 (1) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users did not receive care and support in safe way. The registered person did not assess risks to the health and safety of service users and did not do all that was reasonably practicable to mitigate such risks. The registered person did not ensure that persons providing care and support had the competence, skills and experience to do so safely. Regulation 12 (1) and (2) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to ensure compliance with requirements were not operated effectively. Systems and processes did not enable the registered person to assess, monitor and improve the quality and safety of services. Systems and processes did not enable the registered person to assess, monitor and

mitigate risks relating to the safety and welfare of service users. The registered person did not maintain securely records relating to person employed and the management of the regulated activity.

Regulation 17 (1) and (2) (a) (b) and (d) (I) and (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled, and experienced persons were not deployed. Persons employed did not receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18 (1) and (2) (a)