

Voyage 1 Limited

Ruddington View

Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

We conducted an unannounced inspection at Ruddington View on 15 November 2018. Ruddington View is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ruddington View accommodates up to eight people in one building. On the day of our inspection, five people were using the service, all were people living with a learning disability. This was the first time we had inspected the service since they registered with us.

Ruddington View is a new model of care that aims to enable people with learning disabilities to live and remain in their local community. Although the size of the service exceeds the maximum of six people as specified in the CQC policy, Registering the Right Support. It had been developed in line with the Registering the Right Support values of choice, independence and inclusion. Ruddington View was developed in response to the national 'Transforming Care' agenda, which aims to improve health and social care services so that more people with a learning disability can live in the community.

Within Ruddington View there are two short term 'unplanned care' apartments, offering support to people who may be in a period of crisis and require additional support to remain in the community. The remaining six places are 'step down', these are for people who have been in long term hospital placements who require support to enable them to move into the community. Ruddington View is staffed by support workers with specialist input from a behaviour therapist.

There was a registered manager in post at the time of our inspection visit; however, they left their post during the course 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.

During this inspection, we found the service was not safe. Risks associated with people's behaviours were not managed safely. Risks had not always been assessed and there was a lack of guidance about how to manage some people's behaviours. Staff did not always have the skill or guidance to respond appropriately in risky situations. This placed people who used the service and staff at risk of harm. Opportunities to learn from incidents had been missed. When incidents had been investigated the actions taken were not timely and did not reduce the immediate risks to people. People were subject to restrictive interventions that did not respect their rights. The use of medicines to manage people's behaviours was inconsistent. There were not always enough suitability qualified staff available to meet people's need and ensure their safety. Despite this people told us they felt safe and safeguarding referrals had been made. Overall, the home was clean and hygienic.

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

this practice. Although we found most permanent staff had training in key areas, further work was needed to embed learning into practice. Staff did not always receive supervision and felt unsupported following potentially distressing incidents. Further work was needed to ensure the environment met people's needs. People had enough to eat and drink and their physical health needs were met. The 'unplanned care' part of the service had been effective in preventing hospital admissions.

Peoples choices were not always respected. There was a lack of consistency in the staff team and this had a negative impact upon the development of trusting relationships with people who used the service. People's right to privacy was not always respected. The approach to building people's independence was inconsistent and not always well planned. Overall, people told us they were supported by staff who were kind and caring.

People did not always receive consistent support. Support plans were not always up to date and did not reflect people's needs. The risk of inconsistent support was exacerbated by the use of temporary agency staff. There was a risk people's diverse needs may not be met. The approach to social and recreational activity was not well planned. There were systems and processes in place for people to provide feedback and to deal with, and address complaints.

There had been a failure to identify and address some serious issues. Where issues had been identified timely action was not taken to make improvements. Systems to analyse, investigate and learn from incidents were not effective. Staff gave mixed feedback about the support they received from the management team, they told us it was not always well organised and they were not given opportunities to influence the running of the home. Records of care and support were not accurate or up to date. Following our inspection, the provider developed a comprehensive and robust action plan detailing actions taken and planned to make improvements and reduce risk.

This was the first time the service had been rated as Inadequate. During this inspection, we found five breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Risks associated with people's behaviours were not managed safely. People who used the service and staff were placed at risk of harm. Opportunities to learn from incidents had been missed. People were subject to restrictive interventions that did not respect their rights. The use of medicines to manage people's behaviours was inconsistent. There were not always enough suitability qualified staff available to meet people's need and ensure their safety. Despite this people told us they felt safe and safeguarding referrals had been made. The home was clean and hygienic.

Inadequate ●

Is the service effective?

The service was not consistently effective.

People's rights under the Mental Capacity Act 2015 were not protected. There was a risk people may receive care and support from staff who did not have the necessary skills and competency to support them effectively. Staff did not always receive support and supervision. Further work was needed to ensure the environment met people's needs. People had enough to eat and drink and their physical health needs were met.

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

Peoples choices were not always respected. Changes in the staff team had a negative impact on the development of trusting relationships. People's right to privacy was not always respected. The approach to building people's independence was inconsistent. Overall, people told us they were supported by staff who were kind and caring.

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People did not always receive consistent support. Support plans were not always up to date and did not reflect people's needs. There was a risk people's diverse needs may not be met. The approach to social and recreational activity was not well planned. There were systems and processes in place for people to provide feedback and to deal with, and address complaints.

Is the service well-led?

The service was not well led.

There had been a failure to identify and address some serious issues. Systems to analyse, investigate and learn from incidents was not effective. Staff gave mixed feedback about the support they received from the management team. Records of care and support were not accurate or up to date. Following our inspection, the provider developed a comprehensive and robust action plan detailing actions taken and planned to make improvements and reduce risk.

Inadequate ●

Ruddington View

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, to look at concerns we received about the safety of the service and to provide a rating for the service under the Care Act 2014.

Before our inspection, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We also used information the provider sent us in the Provider Information Return in our planning. 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.

The inspection was undertaken by one inspector, a specialist advisor who was a learning disability nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. During our inspection visit, we spoke with four people who lived at the home and two people's relatives. We also spoke with 10 members of care staff, the registered manager, the peripatetic manager and the operations manager.

To help us assess how people's care needs were being met we reviewed all, or part of, three people's care records and other information, for example their risk assessments. We also looked at the medicines records of five people, four staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

After our inspection visit, we asked the management team to send us a copy of various records, policies and procedures, which they did prior to this report being completed.

Is the service safe?

Our findings

Risks associated with people's behaviours were not always managed safely. Risks had not always been assessed and there was a lack of guidance about how to manage some people's behaviours. Records showed one person frequently behaved in a way that placed staff and others at risk. Despite this, there was no behaviour risk assessment and their behaviour support plan was incomplete with little guidance about strategies to reduce risk and deescalate situations. Furthermore, some staff said they used physical intervention with the person. However, their support plan did not describe which strategies were safe to use or how many staff were required to ensure a safe intervention. This meant there was a risk of inconsistent and potentially unsafe support.

Support plans did not contain adequate guidance of how to ensure people's safety. For example, records showed physical interventions regularly failed to be effective with one person. Despite this, their support plan did not provide guidance of what to do if physical intervention was not successful. This had led to risk not being managed safely. During a recent incident where physical intervention did not work the person was able to cause harm to themselves. This lack of guidance placed people at risk of harm.

People were placed at risk of harm as staff did not always have the skill or guidance to respond appropriately in risky situations. This had led to damage to property and others being placed at risk of harm. An investigation into a recent serious incident, identified several concerns about staff practice, including; ineffective planning, communication and a failure to effectively mitigate risk to the person and others.

Staff were exposed to harm. Several staff told us they did not always feel safe at work. Incident records documented several occasions where staff had been exposed to the risk of harm or where they had sustained actual harm. This included staff being threatened, having objects thrown at them and being hit, grabbed and scratched. Records did not clearly evidence what action had been taken to reduce these risks to staff. This exposed staff to the risk of physical harm and emotional distress.

Opportunities to learn from adverse incidents had been missed. Staff told us that although they had reported incidents, nothing had been done and we found many incident records that had not been effectively reviewed or acted upon. For example, records documented a recent incident where a person had caused damage to property after becoming agitated about not having clean clothes to wear. There were no 'lessons learned' documented on the incident form and the only action recorded as taken was 'damage of property reported.' Their support plan had not been reviewed or updated following the incident and consequently there was no information about how to avoid this happening again in the future.

When incidents had been investigated the actions taken were not timely and did not reduce the immediate risks to people. An investigation into a recent serious incident identified several shortfalls. The actions planned to address this did not reflect the seriousness of risk. It was unclear what immediate action had been taken to reduce risk or to address the root cause of issues. For example, it was identified that staff were intimidated so retreated to the house, the investigation report stated that in future staff should remain close to the person. This did not address the concern about staff intimidation. Other actions were not timely. It

was identified that several amendments should be made to support plans; however, this was not scheduled to take place until nearly two weeks after the incident, this was not a timely response to such an incident. This meant there was a risk of recurrence, and this placed people at risk of harm.

There was a risk medicines prescribed on an 'as required' basis may not be administered appropriately. Records did not always evidence that 'as required' medicines for anxiety and agitation were given as a last resort and administration was inconsistent. For example, an incident record documented that a person was administered 'as required' medicine when displaying agitated behaviour. The record did not clearly evidence that all steps detailed in the person's support plan had been tried prior to the administration of medicine, nor did it evidence that the person's behaviour was placing them or others at significant risk to necessitate the administration of this type of medicine.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been subject to, potentially avoidable, restrictive interventions. Several staff commented that some staff did not know people well enough and this caused increased behaviours. One member of staff told us, "Sometimes staff do things that I think might provoke people's behaviours. I think to myself, that didn't need to happen." A recent incident record, documented a person wanted to take a nap on the sofa during the day. Staff told the person they must go to bed if they wished to sleep. This resulted in them becoming agitated, and consequently they were given medicine to reduce their anxiety. This incident may have been avoidable. Furthermore, the review of this incident stated that in the future staff should be consistent and not 'let' the person do things that they don't normally do. However, their support plan had not been updated to reflect this. This meant there is a risk the same may happen again and this placed the person at risk of unnecessarily restrictive interventions.

The lack of clear guidance about managing behaviour had led to restrictive interventions being used to manage risk. A recent incident record documented that staff had held the front door closed to prevent a physical altercation between two people. This meant one person was unable to leave the building. This was a restrictive intervention which did not respect people's rights. Staff told us they knew they should not have done this but they did not know what else to do.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough suitability qualified staff available to meet people's need and ensure their safety. This was reflected in the comments of people using the service. One person told us, "More staff would be better." Another person commented, "There isn't enough staff, sometimes I can't go out if there isn't enough staff."

Staff told us the service was short staffed and that agency staff were used frequently. One staff member told us, "Ninety percent of the time we are short staffed." Staff said the use of agency staff had a negative impact on the quality of the service. A member of staff commented, "Some of the agency staff don't know the people in the service, which causes a lot of behaviours as they don't understand the triggers." Another member of staff told us, "Sometimes I don't feel safe as some of the staff are new or are agency workers."

Staff did not all have sufficient knowledge or competency to ensure people's behaviours were managed safely. We reviewed the profiles of agency staff and found staff did not all have training in key areas such as learning disability, mental health or MAPA. Staff reported this had a negative impact upon the safety of the

home. For instance, a member of staff told us of a time when agency staff had not responded to the panic alarm being pressed. Luckily this was a false alarm. Some staff spoke of recent incidents and said they felt they would not have happened had there been more trained staff on shift. They specifically said they felt the service was not safe at these times.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, people told us they felt safe at Ruddington View. One person told us, "I'm not bullied here and (staff) look after me." Another person said, "I'm safe when I go out with staff, they keep me safe." Most staff had been trained in recognising abuse and were able to identify examples of this. They had knowledge of the local safeguarding procedures and said they would raise concerns if required. Records showed the registered manager had made referrals to the local authority safeguarding teams when allegations of abuse had been made. There were several safeguarding investigations ongoing at the time of our inspection.

In contrast with the above information, we found routine medicines were managed safely and records showed people received their medicines as prescribed. People told us they got their medicines when they needed them. One person told us, "I get my tablets on time. Staff look after my tablets and they're good at that. I've never not given my tablets." Overall medicine records were completed accurately to show people had been given their medicines. There were some gaps on medicine records but, this had been identified and was being addressed to reduce the risk of this happening again. Staff that we spoke to told us that were trained in administering medication. However, some of the staff felt that they required further training as errors had been made in the past.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Overall, the home was clean and hygienic and effective infection control and prevention measures were in place. Communal living areas and equipment were cleaned to a sufficient standard. Some people were supported to clean their own bedrooms, staff told us they were working with these people to improve hygiene and cleanliness standards. The Food Standards Agency had inspected the home in March 2018 and given it a food hygiene rating of five, which means very good. During our inspection we found some food items had not been labelled as required. Staff took immediate action to dispose of unlabelled food.

There were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal evacuation plans detailing how each person would need to be supported in the event of an emergency such as a fire and regular environmental checks were completed.

Is the service effective?

Our findings

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 rights under the MCA were not protected as the Act had not been applied to ensure decisions were made in people's best interests. Mental capacity assessments had not been completed when people's capacity to consent was in doubt. The registered manager told us no mental capacity assessments had been completed for anyone living at the home. Throughout our inspection we observed that staff frequently made decisions on behalf of people without the legal authority to do so. This meant people at Ruddington View were subject to restrictions upon their rights. For example, one person was not able to access the front or back garden areas due to risk. Throughout our inspection, we saw the person repeatedly requested to go out and staff declined their requests. This meant people's rights under the MCA were not respected.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. DoLS had been applied for as required, all applications were awaiting authorisation at the time of our inspection.

There was a risk people may receive care and support from staff who did not have the necessary skills and competency to support them effectively. Although records showed that most permanent staff had up to date training in key areas, further work was needed to embed this learning into practice. Staff commented, and we found, that some staff, primarily temporary agency staff, did not have adequate training or experience to provide effective and safe support. A member of staff told us, "I feel that some of the staff are not experienced enough to deal with the people in this service." Another member of staff said, "The staff team have varying skill, there are some good staff but others are not, they lack specialist knowledge." This had resulted in a lack of skill in the staff team and meant staff did not always have the skills required to keep people safe. We have reported further upon in this in the 'Is the service safe' section of this report.

Furthermore, staff provided mixed feedback about the training provided. Some staff said the training was good quality; however, others commented that it did not fully prepare them for the role. For example, one member of staff told us, "The people in this service are extremely challenging, we were told in training that we wouldn't be using MAPPA often, but we do it up to five times a day." This had contributed to a high turnover of staff since the service opened. This had a negative impact on the quality and consistency of the

service people received.

Health and social care professionals told us there had been some over-reliance on health professionals and there had also been a high volume of calls made to the police to support the staff to deal with behavioural incidents. This demonstrated staff did not always have the skill or competency to provide effective support.

Staff did not always receive adequate support or debrief following incidents. Most of the staff we spoke with felt unsupported following incidents where the people who used the service had been verbally and physically aggressive towards them. One staff member said, "It would be nice to have a break and a cup of tea and to be asked if you are ok, that doesn't happen." Another member of staff said, "We are subject to a lot of abuse as a staff team, the support is getting better. We sometimes get to vent frustrations, but this depends on who is on shift." There was no formal system to support staff following potentially distressing incidents. This meant staff were not given the opportunity to reflect on their practice and discuss their feelings.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was not suitable for people's needs. Ruddington View was situated in a residential premises, which had been adapted to accommodate the service. The home was split into four self-contained apartments and a main house, there was also a large garden area. Due to complex relationships between people living at the home, resulting in altercations between people and damage to property, some people had restricted access to the garden area. This meant there was a lack of outside space available for people. One person told us, "I want a different garden. I don't get on with other people." Incident records showed that noise from other parts of the home had also led to people experiencing anxiety and distress. The provider had undertaken significant work to try to improve the environment for people, such as creating small outside areas at the front of the home for people to use and removing stones from the garden to prevent further damage to property. This work was ongoing at the time of our inspection. In addition, at the time of our visit several windows had been smashed and were boarded up awaiting repair. The provider advised us windows were due to be replaced with Perspex to reduce future damage and risk.

People had enough to eat and drink. People were positive about the food at Ruddington View. One person told us, "The food is awesome." People had a choice about what they ate and were supported to get involved in food preparation where possible. Although staff told us they supported people to make healthy choices some further work was required in this area to ensure consistency. One person had identified a goal to lose a certain amount of weight each week. There were no clear plans in place to guide staff support and records showed the person's weight had increased steadily since they had moved to Ruddington View. People's diverse dietary needs were identified and catered for. One person had a health condition which was managed by a specific diet, the team had purchased foods to meet their needs.

There was a risk people may not receive person-centred care and support when they moved between different services. For example, 'hospital passports' had been developed for people living at the home. However, these had not all been fully completed for all people living at Ruddington View. This meant there was a risk people may not receive person centred care.

People were supported with their day to day healthcare needs and were given support to attend regular appointments. People told us if they needed to see health professionals this was arranged for them. One person said, "Staff take me to see the GP." Staff also told us people received support from health and social care professionals including visits from psychiatrists, doctors, nurses and social workers. Staff made referrals

to physical and mental health specialist teams when advice and support was needed. People had their health needs detailed in both their support plan and health action plan.

The 'unplanned care' part of the service had been effective in preventing hospital admission. For example, one person had started using the service in a period of crisis. The mental health team had suggested admitting the person to hospital due to a deterioration in their mental health. However, the staff team continued to support the person at Ruddington View while their medication was reviewed and consequently managed to prevent admission to hospital. The registered manager also shared other stories where people has moved into Ruddington View on the verge of family crisis or breakdown. Several people had moved back home successfully after a short stay at the service.

Is the service caring?

Our findings

There was a lack of consistency in the staff team and this had a negative impact upon the development of trusting relationships with people who used the service. Staff told us they had good relationships with people. For example, a member of staff commented, "I've got a fantastic bond with [person]." However, we found this was based upon the approach of individual staff members rather than a culture of person centred support. One person explained it was hard to get to know staff as there had been a high turnover of staff, they commented, "The staff don't come back." Another person told us, "Some staff listen others just walk away." This meant people did not receive consistently person centred support.

People's choices were not always respected. People told us they did not always feel listened to. One person said, "I'm in charge of myself and I don't like people telling me what to do." They went on to tell us about restrictions upon their choices and we observed this was the case during our inspection. Another person told us about situations where staff had made choices on their behalf. There were no capacity assessments to demonstrate these people were unable to make these decisions. This meant people's choices were not always respected.

People's right to privacy was not always respected. Before our inspection we received concerns that people's privacy was not respected as there were not sufficient window coverings to prevent others from looking in. At the time of our inspection this continued to be a concern. Staff told us the lack of privacy had a negative impact on people's freedom to express themselves. The registered manager told us they were waiting for films to cover the glass to be provided. Following our inspection, the provider told us this had been addressed.

The approach to promoting and building people's independence was inconsistent. Approaches to building people's independence were not always well planned. For instance, staff described how they had taken a person shopping in the town centre. This was not an experience the person was accustomed to and staff told us there was little planning. Consequently, staff described the trip as "chaotic." It did not enable the person to grow in independence. This did not demonstrate a planned or coordinated approach to promoting independence. In contrast, there had been successes in other areas. One person had been supported to get a voluntary job in a local shop, a second person was supported to manage their own money and a third person had developed skills in self-care. Further work was needed to ensure a planned and consistent approach was in place for every person at Ruddington View.

Overall, people told us they were supported by staff who were kind and caring in their approach. One person told us, "Some of the staff are kind. Staff were really kind when I first came here." People's relatives were equally positive about the approach of the staff team. One relative told us, "Staff are kind and caring from what I have seen. [Relation] has never complained about staff. The staff I know are very nice especially [name] who is an angel on legs." Throughout our inspection we saw positive interactions between staff and people using the service. Staff were patient and friendly and people looked relaxed in their company. People had been supported to do things that were important to them. One person had written a letter to the queen, another person had been supported to purchase items to enable them to pursue their interests.

Is the service responsive?

Our findings

People did not always receive consistent support. This was reflected in our observations and in feedback from people's relatives. A relative told us, "I have asked staff that [name] doesn't buy [specific items] but some staff let them and then the management take them away from [name]. We all need to be singing from the same hymn sheet." Consistency and boundaries were particularly important for the group of people at Ruddington View as they needed structure, routine and stability to maintain their wellbeing. The lack of consistency placed people at risk of distress.

Support plans were not always up to date and did not reflect people's needs. Staff told us that although support plans were detailed they were not updated regularly so were not accurate. A member of staff said, "Information in the care plans is good but things are always changing and they're not always updated." There was no evidence that support plans were reviewed following incidents or changes in people's circumstances. For example, one person's support plan had not been updated since July 2018 and contained information about their personal relationships and daily routines that were no longer accurate. This placed people at risk of receiving inconsistent support that did not meet their needs. This risk was exacerbated by the use of temporary agency staff who were asked to read care plans prior to supporting people.

There was a risk people's diverse needs may not be met. Support plans did not clearly reflect people's diverse needs and this resulted in staff providing inconsistent support to people. One person who used the service had support needs relating to their individuality and how they expressed this. Their support plan did not contain any information about this and staff told us the support the person received varied depending upon staff member. A member of staff told us, "You see some staff encouraging it, not me, I tend not to talk about it." This meant the person received inconsistent support in this area and posed a risk their diverse needs may not be met.

Prior to our inspection we received concerns that people were not provided with encouragement or opportunity to take part in social activity. Our findings were mixed. Some people were supported to take part in a range of activities at home and in the community. In contrast, records for other people showed very little meaningful activity. The registered manager explained that some people's level of activity was limited by factors such as poor sleep patterns or by a history of living in institutionalised settings. They said the staff team were working on those areas first to help people engage in more activities. However, the approach to this was not well planned. For example, we were told one person did not take part in many activities due to poor sleep habits. Despite this there was no plan in place about improving their sleep habits. This meant the person was not receiving consistent and coordinated support to enable them to take part in a full range of social and recreational activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems and processes in place for people to provide feedback and to deal with, and address

complaints. People told us they would feel comfortable telling the staff if they had any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the registered manager would act upon complaints appropriately. There was a complaints procedure displayed in communal areas which detailed how they could make a complaint. Records showed complaints had been handled in line with the provider's complaints policy and work was ongoing to resolve some complaints from the local community.

The service was working towards meeting its duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. We saw that information was displayed around the home in a format people could understand. An individualised approach had been taken to meeting people's communication needs, but further work was required to ensure consistency in this area. For example, social stories were used with one person to help them understand social situations. Social stories are short descriptions of a situation, event or activity, which include specific information about what to expect in that situation and why. However, these had not been used consistently and the failure to use social stories had been identified as a trigger to the person's anxiety and agitation.

Although the service was not supporting anyone who was coming toward the end of their life at the time of our inspection, the registered manager told us people would be supported to discuss their wishes for the end of their lives if the need arose.

Is the service well-led?

Our findings

There had been a failure to identify and address some serious issues at Ruddington View. Although the provider conducted regular audits at the home these had not identified the scale and extent of concerns at the home. The most recent audit completed in Autumn 2018 had identified some issues; however other concerns about the safety and leadership of the home had not been identified. The failure to identify and address these issues placed people at risk of harm. Action was not always taken to address known issues. An audit conducted by the provider in spring 2018 had identified that mental capacity assessments needed to be conducted in key areas. This had not been addressed and remained an issue at the time of our inspection. This failure to take swift action in response to known issues had resulted in people's rights under the MCA not being protected. Furthermore, a lack of reflective practice following incidents had a negative impact upon staff morale and retention of staff.

The registered manager told us they were aware improvements were needed in some areas of the home. They said they had not been able to prioritise this work due to being very involved in the day to day operations of the home. They spent a significant proportion of their time talking with people who used the service and liaising with external health professionals. This had had a negative impact on the quality of the service at Ruddington View.

There was no effective system for analysing, investigating and learning from incidents. A behaviour therapist, employed by the provider, had completed an analysis of behavioural incidents. However, trends of incidents, such as the location, timing or staff involved were not effectively analysed and no changes were made to support plans as a result of the analysis. This failure to conduct effective analysis of incidents meant opportunities may have been missed to identify ways of preventing future incidents and exposed people to the risk of potential distress or harm.

We received mixed feedback about the management and leadership of the home. Staff had mixed feelings about the support they received from the management team. Some staff were positive and told us they felt they could go to the management team with concern. In contrast, other staff said there was a lack of communication and consistency from management. Some staff told us the service was not always well managed or organised. One member of staff commented, '(We need) more leadership and organisation.' They told us issues with the leadership and management of the home had a negative impact on staff morale. Several staff commented that the emotional impact of work was not always considered when allocating roles. Specific staff were routinely allocated to work long shifts with particular people. A member of staff told us, "Sometimes staff on shift are not deployed well, if a relationship works staff can end up doing a 14-hour day with [name] this is not good for either of them. It is not good management." This had a negative impact upon the physical and emotional wellbeing of staff and some staff voiced concerns that this also had a negative impact upon relationships between people who used the service and staff.

The registered manager told us they tried to respect the diverse needs of the staff team, such as making changes to the rota to accommodate people's religious routines and caring responsibilities. However, some staff did not feel supported in this area. For instance, staff commented that they received their rota on a

weekly basis, they said this made it hard to accommodate personal commitments. Staff also told they were not always protected from discrimination. Several incident records showed some staff had been subject to racist comments from people living at the home. Staff said they did not receive support with the emotional impact of this and there was no evidence of action taken to try to reduce the likelihood of this happening again.

Staff did not feel involved in the running of the home. Although there were regular meetings for staff, these mainly focused on trying to address performance issues. The impact of this approach was reflected in comments from staff. One member of staff told us, "We were being blamed all the time for incidents." This did not promote an open and transparent culture of learning, development and improvement.

Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. Support plans were not accurate or up to date. In addition, records of care and support, such as food records, were also not fully completed. The failure to ensure complete and contemporaneous records meant we were unable to identify if people had received the care and support they required.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection, the provider had identified some additional support was required within the home. Consequently, they had deployed a support manager and employed a full-time administrator to try to reduce the registered manager's workload. Two experienced deputy managers had also recently started at the home and they had had a positive impact on some areas of the home, such as medicines management. Following our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed a comprehensive and robust action plan detailing actions taken and planned to make improvements and reduce risk. Additional resources were immediately deployed to the service including enhanced management support and a full-time behaviour therapist. The provider shared examples of revised support plans and risk assessments to evidence improvements made. We were informed the registered manager left the service during the course of our inspection, temporary management cover was deployed and the provider took action to start the recruitment of a new manager.

People who used the service were involved in some aspects of the running of the home. One person had worked with staff to develop a newsletter for the home. Another person had been involved in developing a promotional leaflet for the service. People had also been given the opportunity to provide feedback about the service in a satisfaction survey. The results of this were positive.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service.

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 People did not always receive consistent support that met their needs. Regulation 9 (1)
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the MCA were not protected. Regulation 11 (1)
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's behaviour were not managed safely. Opportunities to reduce risk had been missed. Regulation 12 (1)
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were subject to restrictive interventions.

Regulation 13 (1)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

Systems to ensure the safety and quality of the service were not effective.

Regulation 17 (1) (2)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

There were not always enough suitably qualified staff available to meet people's need and ensure their safety. Staff did not always receive adequate support to enable them to undertake their role effectively.

Regulation 18 (1)