Encompass (Dorset)

Rawleigh House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 September and 4 October 2017.

The service is registered to provide care and accommodation for up to six people who have a learning disability. At the time of our inspection six people were living at the service.

Although there was a registered manager in post at the time of the inspection they were unavailable. At the time of the inspection the home was being overseen by an interim manager and interim deputy manager. 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.

At the last inspection carried out in November 2015 no concerns relating to the care and support people received had been identified. At this inspection we found the service required improvement.

People had not been fully protected from the risk of abuse because staff told us they were not always confident in raising concerns. Risks to people's welfare and safety had not always been assessed and managed appropriately Allegations of abuse had been raised by staff with the provider. One member of staff told us, "There has been a culture of bullying, but it feels much better now".

Prior to our inspection we received information of concern in relation to the safeguarding of people from harm and improper treatment. These concerns included safeguarding concerns around the unsafe treatment of people living in the home. The concerns continued to be investigated whilst this inspection took place. Staff told us they had been dissatisfied and concerned in their work before changes to the management of the service had taken place.

On receiving these concerns the provider had acted to ensure people were safe and protected from immediate harm and abuse.

Systems in place to assess, monitor, manage and mitigate risk were not always effective. This meant people were at risk of receiving unsafe care and treatment. There was not a culture of openness that ensured staff

had the confidence to speak out about concerns in regards protection of vulnerable adults.

People were supported by staff who knew them well, however, people's privacy was not always respected. When staff discussed people's care needs they did not do so in a confidential manner. People did not have access to communication aids that would promote the knowledge and independence.

Staff did not respect people's communal areas and stored their own personal items around the home and took their breaks in communal areas.

We recommended to the provider they reviewed their methods of communication in regards decision making and choice, and to look at accessible information standards.

The requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were not being met Where people had restriction on their choices, best interest decision making process were not in place. People were not always consulted in decision in regards restriction on their movements.

People received help with their medicines from staff who were trained to safely support them and who made sure they had their medicine when they needed it. The provider undertook regular competency checks on staff to ensure they followed safe practice when supporting people.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people effectively. Staff were positive about their training opportunities. Staff had attended training in safeguarding people and had access to the organisation's policies on safeguarding people and whistle blowing.

Training certificates in staff files confirmed the training staff had undertaken, which included safeguarding of vulnerable adults, manual handling, infection control and the Mental Capacity Act 2005 (MCA).

The service had a complaints policy and procedure which was available for people and visitors to view in the home.
To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks.

We have made recommendations to the provider they seek guidance from the accessible information standards in relation to supporting people's communication needs

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read at the back of the full report what action we have told the provider to take.

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.

Risks to people's health, safety and welfare were not assessed and mitigated.

Safeguarding incidents were not dealt with and reported appropriately, putting people at risk of abuse and harm

There were sufficient numbers of suitably experienced and trained staff to meet people's needs.

People received their medicines when they needed them from staff who were competent to do so.

Is the service effective?

Requires Improvement

The service was not always effective

People's capacity to make decisions about their lives had been considered or assessed. However where restrictions were in place the principles of the MCA (2005) had not been followed.

People were offered a choice of meals and drinks that met their needs and preferences.

People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Requires Improvement

The service was not always caring

People were supported in a way that did not always consider their dignity and respect.

People did not have access to accessible information to meet their individual needs.

People and their relatives spoke positively about staff and the

care they received

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans had not been regularly reviewed to ensure they reflected people's current needs.

People had access to a range of activities meaningful to them.

There was a system in place to manage complaints. Relatives told us they knew how to raise any concerns or complaints

Is the service well-led?

Inadequate

The service was not well led.

The quality of the service provided to people was monitored and where there were shortfalls these were not identified.

The leadership and supervision arrangements for staff did not always ensure staff were fully supported to raise concerns.

People and staff had access to their management team and felt able to approach their managers.

Rawleigh House

Detailed findings

Background to this inspection

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

The inspection took place on 29 September and 4 October 2017, and was carried out by two adult social care inspectors and an expert by experience on day one. An expert-by-experience is a person who has personal experience of using services or caring for someone who uses this type of care service. Day two was carried out by one inspector.

We didn't request the provider to complete a PIR. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection took place we gathered information from local authority safeguarding team and quality improvement team. We also looked at information we held about the home, this included notifications. A notification is information about important events which the service is required to send us by law.

We observed how care and support was provided to people. We spoke with three people who were living at the home, two relatives, operations manager, the interim manager and interim deputy manager. We also met with five staff members.

We looked at four people's care records, four staff files, four medicine administration records and the training matrix as well as records relating to the management of the service.

Requires Improvement

Our findings

The service was not always safe. Although two people who were able to speak to us told us they felt safe and liked living at Rawleigh House we identified concerns where people's welfare and safety was being compromised and they were being put at risk.

People had not been fully protected from the risk of abuse because staff told us they were not always confident in raising concerns. The provider told us they had ensured safe systems were in place, through internal investigations, and memos to staff reminding them to "Raise any concerns to them immediately". They informed us they also ensured all staff received additional safeguarding training. Staff informed us they were aware of the providers safeguarding policy and knew what constitutes abuse, however they had not been confident to raise concerns for a number of years. One member of staff told us, "There has been a culture of bullying, but it feels much better now". Another member of staff told us, "Staff morale has been low for a long time. With the recent changes I would now feel confident to raise concerns."

Prior to our inspection we received information of concern in relation to the safeguarding of people from harm and improper treatment. The provider informed us, a joint investigation with the local authority had taken place which had resulted in consultation with staff, changes to the management of the home, and additional senior management presence within the home.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. Risk assessments were in place relating to health and safety and fire safety. However we found combustible items were being stored in an upstairs cupboard. We discussed our concerns with the manager in regard the fire risk of storing the combustible items next to other combustible items. On the second day of the inspection the operations manager arranged for the combustible items to be moved to a place of safety. We informed the fire service of our concerns.

There were arrangements established to protect people from the risk of financial abuse. Some people managed their own money but others needed support. The operations manager carried out audits and checks each month and reviewed whether people's money was managed appropriately and safely. People received support from staff whilst out in the community in regards accessing their money. Records were kept and signed on all transaction.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. Rotas evidenced shifts were covered The manager monitored that there were sufficient staff

available on each shift, they informed us, there were vacancies within the home which agency workers were covering. People received one to one support where needed by personal assistants [PA]. One member of staff told us, "Staff morale has been low, we have been low on staff but it seems to be getting better now". Another member of staff told us, "We are a good team and will cover extra shifts to ensure there is the correct cover. The manager informed us the same agency staff were used to ensure consistency for people living at the home.

Staff records contained all the relevant checks to ensure that only suitable people were employed. Staff records included a Disclosure and Barring Service check, which identify if prospective staff had a criminal record or were barred from working with children or adults. Application forms, two references and interview records and evidence of resident in the UK. However two of the files we checked did not hold full employment history. We discussed our concerns with the operations manager who arranged an immediate review of all personal files. Other files we checked did hold the relevant employment checks.

Systems were in place to ensure people received their medicines safely. Staff had received medicine training and were assessed as competent before they were able to administer medicines. Staff confirmed they had received this training. The medicine folders contained a range of information including: a description of how the person liked to take their medicines, reviews with the GP and a body chart for the application of skin creams. Four of the six people living at the home had their medicine administered in the privacy of their bedrooms. There were suitable secure storage facilities for medicines which included secure storage for medicines which needed refrigeration and those that required additional security.

Staff were able to discuss the risks associated with the medicines people were receiving including specific health concerns. One person was receiving their medicine covertly. This meant they were having their medicines administered in a disguised form such that the person would not know that they were taking them. The appropriate risk assessment and best interest documentation were in place to support this practice.

Requires Improvement

Our findings

The service was not always effective. We checked whether the service was working within the principles of the Mental Capacity Act (2005), and whether any conditions on authorisations to deprive a person of their liberty were being met.

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.

Staff understood how the principles of the MCA applied to their work, however, they were not following the principles. For example, one person who smoked had a restriction on the amount of cigarettes they were given in a day. There was no records of how this decision had been made or who had been consulted in the decision making process. One staff member told us, "It has always been like that since [person's name] moved here". Another member of staff told us, "I think we should be able to give [person's name] a cigarette when they want one, a lot of staff smoke when they want in front of [person's name]." Minutes from a staff meeting held in August 2017 identified the person "Struggles" to manage the allocated amount particularly when out or anxious. The operations manager told us that there were a number of practices in the home which were historic and they would be "Reviewing some practices in regards people's choices".

Some people who lived in the home were able to make decisions about the care and treatment they received. We were informed one person liked to be consulted about any changes to their support or routine. However decisions were being made without their consent. For example, there were recent changes to the person's behaviour plan which meant that staff would be using break away techniques, which also included agreed holds and restraints techniques when the person became anxious. Discussions had not been held with the person or their representatives in regards the change to their support. Staff told us, the person would be able to understand the changes, to their support. Following the inspection the operations manager told us. The person had not been consulted as it would make them anxious. They had however shared the new plan with the person's representative.

This is a breach of regulation 11 Health and social Care Act 2008 (Regulated Activities) Regulation 2014. Consent

People were observed being asked for their consent before staff assisted them with any tasks. One member of staff told us, "People get choice about what they want to do, for example bath shower, what they would like to eat. People had 'circle of friends' documentation in their care plans. The circle of support identified if people had received support from family, other health professionals in regards decision making. One person records showed us the 'circle of friends' support had agreed it was in a person's best interest to have their medicines covertly. The decision making process included family members and GP.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had made applications for authorised DoLs and conditions were being met.

People were supported by staff who had undergone an induction programme which was delivered by accredited trainers. This gave them the basic skills to care for people effectively. In addition to completing induction training, new staff had opportunities to shadow more experienced staff. This enabled them to get to know people and how they liked to be cared for. The operations manager told us the provider's induction programme was linked to the Care Certificate. The Care Certificate is a national qualification designed to ensure that staff who are new to care gain all the skills they need.

After staff had completed their induction training they were able to undertake further training in health and safety issues and subjects relevant to the people who lived at the home. Many staff had nationally recognised qualifications in care which helped to ensure they were competent in their roles. Staff told us training was good, and were positive about their training opportunities. The training matrix identified training which had been completed and dates when training needed to be renewed.

Staff said they received support, although they had not always received formal one to one supervisions with their line manager. One member of staff said, "We used to be supervised in small groups, since the change in management we now have one to one supervisions. It so much better". Records showed supervision had not been completed on a regular basis. The deputy manager told us, they had begun to implement regular supervisions for staff. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Where required people had safe swallow plans. Meals were planned by staff weekly with input from the people about their choices. However there were no communication aids or prompts to show people what choices had been made. The weekly menu was displayed on the notice board in the dining room. This was handwritten into a typed template. There was no pictorial display of the day's menu which could prompt or remind people of what their choices had been.

We recommend that the provider considers the accessible information standards.

People with dietary concerns had a personal development plan [PDP] to ensure that they received the correct diet and had their weight monitored monthly. One person PDP held clear guidance for staff on the texture of the food, and position the person needed to be in to prevent the risk of choking. Staff were able to demonstrate awareness of the person choking risk if given the wrong food. One person told us, "I like the dinners, macaroni cheese is my favourite - and toad in the hole". Snacks and drinks were available throughout the day and night. Another person told us, "I like buying my own bits of food and drink, [name] is my favourite supermarket and I can put everything away in my cupboard which is really good".

People had access to external health professionals. Where people's health needs had changed, staff worked closely with other health professionals to ensure they received support to meet their needs. Care records confirmed visits to the service from GP's when people required treatment. Documentation was updated to reflect the outcomes of professional visits and appointments.

Requires Improvement

Our findings

The service was not always caring. Staff told us they were aware of confidentially and treating people with respect and dignity. However, we found examples when privacy and confidentiality was not respected.

We observed when staff discussed people's care needs they did not do so in a confidential manner. For example, staff were overheard discussing one person within a group at their staff meeting. The meeting was held in the main lounge of the home. Confidential information was discussed in the presence of members of the public working in the home, and other people who lived at the home. This meant the person's privacy was not maintained at all times.

Staff did not consistently promote respect for people. Staff were heard on both days of the inspection speaking about people in front of others living in the home. Staff used the main lounge area of the home to store their personal belongings, to take their breaks and complete personal activities. For example, one member of staff was seen relaxing and engaging in an activity, we asked if they were supporting someone with the activity. We were informed, "No I'm on my break". The operations manager informed us if staff were working a long shift they were entitled to take a break for one and half hours. Staff told us they could leave the home if they choose to or stay at the home. One member of staff said, "We normally stay at the home but were not on duty". This meant although staff were around the home they did not have to offer support whilst on their breaks.

Staff were not respectful of the person's home, and were seen to spend periods of time chatting in the smoking area outside of the home. The person that was restricted from smoking was often standing with staff whilst they smoked. People spent time in the lounge. The television remained on during the day, with people taking little interest in it. We asked one member of staff what assistive technology was available to support people to watch TV or communication aids to find out how a person is feeling. We were informed "There are no charts or aids to help". We asked how staff find out how a person who cannot communicate is given choice. We were informed, "We just know people and what they like".

People's communication needs were not being consistently met. Information was not presented to them in a way which enabled them to make informed choice or judgements. People did not have access to information that was accessible in different styles or formats to promote their independence such as photos, symbols or easy read guides. Minutes of residents meeting were in a typed format. Notice boards containing information relevant to people such as menus and information on what to do in the event of an emergency were also typed and held no pictorial guides. People were unaware of who would be supporting

them as rotas did not show pictures of staff coming on and or off duty.

Documents we reviewed made reference to people giving feedback on the home and the support they received. The minutes of the last residents meeting in August 2017, recorded amongst other items on the agenda agreement to the cooker being replaced. The minutes of the meeting were in type form and would not have been understood by all people in the home. We asked the operations manager what communication tools had been used to show people what would be happening. The operations manager agreed, not all people living at Rawleigh House would have been able to give their agreement or understand what would be happening in the home. The operation manager informed us, "Communication formats need to be addressed" They told us it would be an issue they would address and improve on.

This is a breach of regulation 10 Health and social Care Act 2008 (Regulated Activities) Regulation 2014. Dignity and Respect

People were supported by staff who knew them well. Staff were seen to communicate with people, using slower speech. One member of staff told us "We get to know people so well that they're like family and we care about them in the same way as you would a member of your family".

The home was spacious and had smaller areas for people to relax in. One person who liked to sit away from others had their own lounge area where staff were seen to join them for interaction. Most people received one to one support throughout the day. A relative told us, "They [staff] are all lovely and some go the extra mile…. you feel you can approach the acting deputy manager and that what you say will be acted upon." A second relative told us, "Communication is easy, there's a weekly telephone call and we think [relative] is doing really well there".

People were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. Rooms were personalised with pictures, soft furnishing and soft toys according to individual taste.

Requires Improvement

Our findings

The service was not always responsive. People did not always receive care that was responsive to their needs and personalised to their wishes and preferences.

Each person had a care plan which contained information to assist staff to provide care in a manner that respected their needs. and individual wishes. However where changes were made people or their representatives had not always been consulted. For example, staff informed us they now "Reminded" one person they may not be able to continue to live at the home if they displayed behaviours that challenged. Staff confirmed the person had often been 'reminded' of this. Although the person's behaviour care plan had been updated and changes implemented, there were no record that showed the person was aware their placement was at risk or other health professionals had been involved in the review of the placement. Following the inspection the operations manager informed us the new behaviour plan had not been discussed with the person due to concerns the person would become anxious. They informed us they were however sharing it with other professionals involved in the person's support.

An activity programme was on display in the dining area. A laminated sheet set out the hours worked by each personal assistant and the planned activity, (personal assistants are additional staff who are rota to provide one to one support). Information was not available in larger display or pictorial form for the person who would be receiving the activity to be able to see what activity would be taking place or who would be supporting them. This meant people relied on staff to inform them of any changes to their activities or staff who would be supporting them.

This is a breach of regulation 9 Health and social Care Act 2008 (Regulated Activities) Regulation 2014. Person- centred care

Whilst there systems were in place to review peoples care records. Records seen showed reviews of care plans had not taken place since 2015. Records were out of date and did not include accurate, clear information in line with people's identified needs. The provider told us they were currently reviewing their systems and moving to an on line system. They informed us this would support them in ensuring all care plans were up to date with a regular review system in place.

People were able to take part in a range of activities according to their interests. At the time of the inspection people were supported to different activities outside the home. On the first day of the inspection people were supported, to day services, and shopping. Rawleigh House has access to two vehicles, one with access

for people who were supported by mobility aids.

Some people told us they were happy with their activities. Activities included, Tea & Chat for older people in the local church hall, shopping and yoga. We asked one person if they liked their garden activity, they said, "Not really, I just like a cup of tea". Another person told us, they loved animals and pets. Staff told us although the person did not have access to animals in their home they often took them to local attractions where animals lived.

The provider had appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. There were mixed comments from relatives in regard the response to complaints. One relative told us they were satisfied any complaints would be dealt with promptly, another felt their complaint had not been responded to in a timely manner. One person told us they would know how to complain, they said, "I completed a questionnaire to see if I was happy. It had questions and smiley/sad faces".

Inadequate

Our findings

The service was not well led. The providers systems had failed to identify concerns prior to our inspection in relation to, safeguarding. Although staff told us they had received training on safeguarding adults, they did not feel confident to raise concerns. Staff told us they had not felt able or confident to raise concerns prior to the changes in the management structure. Staff told us morale had been low and they were feeling "Intimidated and bullied". Staff described a previous culture of feeling they were not listened to.

Systems in place to assess, monitor, manage and mitigate risks to people were not effective. This meant people were at risk of receiving unsafe care and treatment. There was not a culture of openness that ensured staff had the confidence to speak out about concerns in regards protection of vulnerable adults. Although previous safeguarding concerns had been raised the provider had not ensured staff were adequately supervised where concerns could be shared in a confidential environment. Staff told us previous supervisions had taken place in group settings. This meant the leadership of the service had failed to support staff to feel safe to communicate and raise concerns.

Systems to ensure people received consistent caring and compassionate support were not fully effective. People were not consistently treated with dignity and respect and confidentiality was not always considered. Many staff had worked at the home for a number of years, and had known the people they were supporting before they moved to the home. The operations manager told us, they had identified that there is a culture of the "historic practice". They said, "At my last audit we identified [name] always has this for their breakfast etc." We made it an action to ensure more choices were available." The action had not been completed at the time of our inspection which meant the audit had not been effective.

As part of the governance arrangements, the provider had monthly audits which set out areas expected to be monitored by the registered manager. For example, complaints, pressure ulcer incidents, review of previous month's action plan, review of reports from other agency's such the fire department and environmental health. In addition, staffing issues such as supervisions, sickness and absences formed part of this policy. As well as hygiene, cleaning records and maintenance issues. However these audits had failed to pick up issues we found at our inspection, such as risk to people in regards the right for people to have accessible information to ensure maximum support to promote communication. This meant that the systems in place were not effective or robust.

This is a breach of regulation 17 Health and social Care Act 2008 (Regulated Activities) Regulation 2014. Good Governance

Where allegations or concerns had been bought to the provider's attention they had worked in partnership with relevant authorities to make sure issues were investigated. The operations manager told us they were now fully aware there were concerns within the service and had been addressing these concerns and keeping people and their relatives informed of the actions they planned to take to improve the quality of care for the people living at Rawleigh House.

At the time of our inspection the registered manager and deputy manager were unavailable. The home was being overseen by an interim manager and interim deputy manager, who were being supported by the operations manager and other registered managers from the providers other homes. During the inspection process the provider informed us they were implementing additional support by way of a registered manager from one of their other homes three days a week to support the interim manager. One relative told us, "I feel happier now with the current management arrangements in place".

Although staff commented they had not felt able to raise concerns in the past they told us they felt more confident now. Comments included, "It feels better now, safer". "Our new deputy is really good; feel like we can be open and honest now". "We are a good team and happy to raise concerns now". Staff told us they, "Had confidence in the new manager and deputy manager".

The interim manager told us, There had a been a, "Closed door approach, and staff had not felt able to speak openly. They told us, they planned to change that culture by, "Having an open door policy. They said, "I have put the notice on the door anyone can come in at any time. I am still getting to know people and the way the home works, I am consistently around the home seeing what is going on. They told us they were pleased with the support of the new deputy who "Knew the routines of the home well."

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 There were shortfalls in care planning and the delivery of person centred care, people did not have informed choice and control of decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were supported in a way that did not always consider their dignity and respect. People did not have access to accessible information to meet their individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make decisions about their lives had been considered or assessed. However where restrictions were in place the principles of the MCA (2005) had not been followed

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The quality of the service provided to people was monitored and where there were shortfalls these were not identified.

The leadership and supervision arrangements for staff did not always ensure staff were fully supported to raise concerns.