Greenfield Close Residential Home Limited

Greenfields Close

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

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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.

We inspected the service on 2 and 3 June 2015. The inspection was unannounced. Greenfields Close is registered to provide care for up to 30 people. Greenfields Close provides care and support to people with a diagnosed learning disability and/or autism. Some of these people also receive care in relation to diagnosed physical disability. The service consists of a main house and three smaller houses which have been built on the grounds of the main house. On the day of our inspection 28 people were using the service. The site is made up of

Summary of findings

four residential buildings and one activity lodge: Greenfields (17 residents), The Stables (five residents), Kloisters (four residents) beds, the Lodge (activities and staff room) and the new building Aspen (four residents).

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were placed at risk of harm as the systems in place to protect people from harm were not effective. Medicines were not stored safely and there were risks to people of contracting a health related illness due to inadequate infection control systems.

People were supported by staff who did not all have the knowledge and skills to provide safe and appropriate care and support. The providers systems for ensuring there were adequate numbers of staff with the right skills and experience were not effective.

People were not supported appropriately with their nutrition and did not have access to a healthy diet. People were not always protected under the Mental Capacity Act 2005 and had restrictions placed upon their movements without the required authorisation.

People were supported to have access to health care appointments and referrals were made to health care professionals for additional support or guidance if people's health changed.

We saw staff were kind when they spoke with people. However they did not always recognise or respond to people's discomfort and people were not supported with their dignity. Activities were limited. People knew how to raise concerns and we saw concerns raised were acted on appropriately.

People were involved in giving their views on how the service was run, however changes were not always made when people requested them. The systems in place to monitor the quality of the service were not effective and there was a lack of open and transparent culture.

Overall we found significant failings in this service and a number of breaches of regulation. It was evident that there had been a destabilisation of the managerial and staffing infrastructure in place and a lack of day to day leadership, direction and oversight of people's care which led to people experiencing inconsistent and unsafe care. You can see what action we have taken against the provider on the last page of the full report.

Summary of findings

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.

The systems intended to protect people from harm were not effective. There was a lack of security and a lack of risk management which left people vulnerable and at risk of harm.

People received their daily medicines as prescribed. However there was a risk that medicines intended for emergency use were not managed appropriately and medicines were not stored safely.

There were not enough staff to provide care and support to people when they needed it. There were risks to people of contracting a healthcare setting acquired illness due to inadequate infection control systems.

Inadequate

Is the service effective?
The service was not always effective

People were supported by staff who did not all have the skills and experience to support them safely.

People were not supported to maintain their hydration and did not have access to a healthy diet. People were supported to have regular health checks.

People were not always supported to make decisions in relation to their care and support.

Requires improvement

Is the service caring?
The service was not always caring

People were treated with kindness but staff did not always respond when people experienced discomfort.

People were not always supported to maintain their independence and their dignity was not always upheld.

Requires improvement

Is the service responsive?
The service was not always responsive

People were not always involved in planning their care or supported to pursue their interests and hobbies.

People knew to approach the manager with any issues and complaints were dealt with appropriately.

Requires improvement

Is the service well-led?
The service was not well led

Inadequate

Summary of findings

People were involved in giving their views on how the service was run, however changes were not always made when people requested them.

The systems in place to monitor the quality of the service were not effective and there was a lack of open and transparent culture.

There was a lack of day to day leadership, direction and oversight of people's care which led to people experiencing inconsistent and unsafe care.

Greenfields Close

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.

We inspected the service on 2 and 3 June 2015. This was an unannounced inspection. The inspection team consisted of three inspectors, a specialist advisor who specialises in people with a learning disability 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with fifteen people who used the service, although a number of these had significant verbal communication skills and so we relied on extensive observations in all of the houses. We spoke with seventeen members of care and senior care staff, two housekeepers, two team leaders, the interim manager, the registered manager, the regional support manager and the registered provider. We also spoke with two visiting health professionals.

We observed care and support in communal areas. We looked at the care records of nine people who used the service, medicine administration records and staff training records, as well as a range of records relating to the running of the service including audits carried out by the manager and provider. We looked at the environment including bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

People told us or indicated they felt safe in the service. One person said, "I am alright. I am very safe here." Another said, "People (staff) treat us well. They are nice. I can talk to them."

However, people could not be assured that all incidents would be responded to appropriately. Staff we spoke with knew how to recognise and respond to allegations or incidents of abuse and how to escalate concerns. We saw the manager had shared information with the local authority on many occasions when the incidents were of a safeguarding nature. However we found four incidents which had not been shared with the local authority and there was no evidence of any investigation into the incidents. There was no learning from incidents and so the way people were supported was not changed.

We found that the environment was not safe as there was a lack of security around the main house and the smaller houses. This left people who lived there and their property vulnerable to the risk of intruders. In addition, some people who may not fully understand risks when on their own in the grounds of the service would have been able to leave the premises without staff being aware.

One person had attempted, on several occasions, to run out of the car park and into the road and when staff had tried to prevent them from harm this had resulted in injury to the staff themselves. The provider had not taken into account the recommendations of the Health and Safety executive to erect a fence which were made following the investigation of such an incident previously. In addition, there were risks around the unsafe storage of cleaning agents, thermostatic valves not fitted to hot water taps which meant that people could be scalded, and building work around the property had been left in a state which posed hazards to people.

The provider did not have appropriate risk assessments in place to manage risk to people. For example when one person's behaviour became extremely challenging, staff were trained to evacuate the property leaving the person to remain inside. This posed additional risks for that person, particularly in the event of a fire. The provider also did not have systems in place to manage people's, behaviour to ensure that they did not become distressed to the point of their behaviour escalating, which then posed a risk to themselves, other people who lived at the service and staff. Health professionals had offered advice but this was not acted on by the provider.

The service had a 'no restraint' policy and staff had been assaulted by some people who used the service and there were also regular incidents between people who used the service. Staff told us they felt they could not manage this behaviour. Visiting professionals had made recommendations about staff training and management of risk but the provider had rejected this advice. This posed a risk of harm to people already living in the service.

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

The provider did not have effective systems in place to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in the service. Prior to our visit we were told of concerns about staffing levels and the impact this had on people who used the service. Two people who used the service told us staff were rushed. The provider and staff told us that a lot of staff had left the service and they had to rely on a high number of agency staff to provide care and support.

One person told us, "I like permanent staff. I don't know the new staff." Staff raised concerns with us about the high use of agency staff, some of whom did not know the needs of people who used the service and only carried out tasks such as laundry and cooking, which staff said created more pressure on permanent staff. Staff and visiting health professionals also raised concerns that some agency staff had a poor grasp of the English language and this was having an impact on people who used the service, who already had limited communication and understanding. Staff told us the staffing arrangements sometimes resulted in people not receiving the care and support they needed when they needed it.

In addition, the staffing levels placed people and staff at risk. One person had been assessed as needing two members of staff to support them when they became distressed but at night there was only one member of staff present in this house, and we saw there had been a number of incidents involving this person whilst only one

member of staff was present. We saw there had been an incident in another of the houses when a staff member had been left alone and a staff member and someone else who lived at the service had been harmed.

We saw in the main house that there was a lack of time for staff to spend interacting with people who used the service. Staff were focused on tasks such as meal preparation, laundry and supporting people with personal care. We observed people were left for long periods of time without any interaction or engagement from staff. The manager told us that as people were aging, they were needing a higher level of care and support and staffing levels had not been increased to enable people to have these needs met.

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

We looked at how medicines were managed in the service and we saw people were receiving their daily prescribed medicines. However we saw two people had epilepsy and had a history of having seizures. Both people had medicine to be given in the event of a seizure but staff we spoke with were unsure who would give this as they were not trained to do so. This posed a risk that if either of these people had a seizure staff would not have the skills to know how to respond and the guidance was not in the care plans to guide them.

We also saw medicines were not always stored appropriately. We saw in one of the houses that the medicines for all four people who lived in this house were stored in one service user's separate kitchen. The medicines were stored in a lockable facility but the kitchen door was unlocked. In another house medicines were stored in a kitchen cupboard, which was locked but did not provide sufficient security. This meant medicines were not kept securely.

We saw it would be difficult for some medicines to be audited for errors due to a high number of signatures of administration being crossed out by staff on the medicine administration record (MAR). We saw there were some missing signatures on the MAR and although we saw evidence that the person had received their medicines records were not accurate. Staff responsible for supporting people with their medicines told us they felt there were safer ways to manage peoples' medicines such as using a bio dose system which was used for some people's medicines but not for all.

One person was prescribed a medicine to be given as a last resort when their behaviour was escalating and when other de-escalation techniques did not work. Staff were not provided with the guidance of when to use this and no record was made of other strategies used prior to giving this medicine.

People told us they liked their bedrooms and the areas of the service they spent their time in. However we found areas of the home were dirty. In the main house two housekeepers had been employed to keep the house clean. They were completing cleaning schedules and we saw they were using colour coded cleaning materials which would reduce the risk of the spread of infection. Some areas of the service were clean but we had concerns about others. We saw mats which one person laid on during the day were very dirty and these were not included on the cleaning schedule.

We found there were some unpleasant odours in two bedrooms and in the main communal lounge. We found two chairs which had food spillages down the sides of the arms, and wheelchairs with food spillages which had not been cleaned. In the laundry we saw there was mould around the window frame and the extractor fan was covered in dirt. We also found a commode/shower chair in use which posed a risk of the spread of infection as it was damaged and could not be kept clean. We observed a person drying dishes in the kitchen had a condition which caused excessive mouth excretions which dripped onto the tea cloth the person was using. Staff did not observe this so dishes were put away which would pose a risk of the spread of germs.

Two staff did not know how to respond to an outbreak of sickness and diarrhoea in the service despite their having been a recent outbreak. One member of staff said, "I haven't got a clue." This member of staff and 17 others had not received any training in infection control procedures. This posed a risk of the spread of infection in the service.

We saw staff were recruited safely and the manager followed recruitment procedures in order to check that staff were suitable to work with the people who used the service. There was also evidence that if staff concerns about staff were raised the manager investigated these and acted appropriately in response to the concerns.

Requires improvement

Is the service effective?

Our findings

People told us they liked the staff that supported them. One person told us, "The staff are good." Another said, "I like my key worker." However we found people were supported by staff who did not have the knowledge and skills to provide effective care and support. We received information of concern prior to our inspection in relation to staff not being given training which gave them to the skills to do their job safely.

Staff told us they had not had the training they needed to support people safely. One member of staff told us, "Where I've worked before, you were given training in a specific skill and then signed off as competent but that doesn't happen here. You're just told to do things whether you've been trained properly or not." Records we saw supported what staff told us. For example 19 staff who delivered care and support to people were working in the service without up to date moving and handling training. The provider did not have an effective system in place to address the shortfall in training.

The provider did not have effective systems in place to ensure staff were given appropriate support and training. Five staff told us that their induction had been limited to shadowing another member of staff on their first day. They were then put on duty on their next shift as one of the compliment of staff which had left them feeling anxious and unsafe. Some of the staff had never worked with people with a learning disability before and had on occasion been left to work alone with agency staff that were not familiar with people's needs and we saw records that confirmed this. We saw staff that had not had a proper induction supported people who had complex needs that required skilled and trained staff to support them safely.

Most staff had been trained in how to de-escalate challenging and violent behaviour and how to get themselves out of danger if the violence was directed towards them. However some staff told us this did not always work for one person and they were using other inappropriate methods of dealing with the person's behaviour. Staff told us they had been assaulted on frequent occasions in the course of their duties and they found the training they had received on managing aggression did not give them the skills they needed to respond to this. The provider did not provide agency staff used to work at the home with the same training as permanent staff despite agency staff having to support permanent staff in circumstances where people's behaviour escalated and this training may be needed. A health professional had requested further training for staff on how to communicate with a person who had complex needs but this had not been provided.

Additionally staff were not receiving support through having supervision meetings with the registered manager to discuss how they were working. Some staff had been working in the service for up to eight weeks without having support from the management team. Staff told us there was a lack of support for them.

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

People were not always supported to make decisions about their care and support. We observed staff did not always interact with the person they were supporting to let them know what they were going to do. For example one member of staff went to escort a person to the dining area and they didn't explain where they were taking them, they just led them from the area they were sitting.

We looked at how people who lacked the capacity to make certain decisions were being supported and we found the registered manager and staff had an understanding of the Mental Capacity Act 2005 (MCA) but this was not always being applied in practice. The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability. The manager had made some applications for a Deprivation of Liberty Safeguard (DoLS) to the granting authority. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed. However we saw some people had lap belts fitted to their wheelchairs to prevent them from falling or getting out of the chair. The use of lap belts had not been recognised by the provider as a form of restraint and people who had these in place had not been assessed under the principals of the MCA to ensure their liberty was not being restricted.

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

We saw one person had a DoLS in place and the granting authority had placed three conditions in order for the DoLS to be granted. We saw that none of the conditions had been addressed and although the provider was not

Requires improvement

Is the service effective?

compelled to impose them, there was nothing recorded to show if these recommendations had been considered. As a result, some staff told us they had on occasions prevented this person from leaving their bedroom when they displayed violent behaviour to protect the person from harming themselves and others. This method of restraining the person was not documented in the person's care plan as an approved method of dealing with their behaviour and the registered manager was not aware of the practice.

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

Prior to our visit we received concerns about a shortage of food in the service and during our inspection staff raised concerns about the poor quality of the food and a lack of planning for a healthy diet. We saw people with diabetes were not being supported to eat a healthy diet, which is recommended for people with such a condition. We spoke with two people with diabetes about their diet who told us of food they ate that posed a risk to someone with diabetes. One person said, "I have chocolate spread on toast for breakfast and I like baked beans. There are plenty of biscuits in the kitchen so when I'm hungry I just go and get some of those. I can go to the shop in the village and buy sweets as well."

We looked at the kitchens in the houses and we found that there was a heavy reliance on convenience foods such as jars of ready-made sauce and tinned food. All of the food we saw had low nutritional value, was a supermarket's most basic brand and there was a lack of fresh ingredients. Menus lacked healthy options and there was no fresh fruit or vegetables available in the main house when we visited. This was mirrored in two of the smaller houses. Staff told us the food did not meet the nutritional needs of one person who had diabetes.

One person in one of the smaller houses had been assessed by health professionals as needing to have structure around their food and meals. However when we visited at 11.30am we saw the person eat six slices of bread, made into sandwiches and two packets of crisps. Staff were unclear whether this was the person's breakfast or lunch and so it was clear the nutritional structure was not in place. We observed that the food being provided to people did not meet their diet plans. This meant there was a risk people's nutritional needs were not being met.

When people had been assessed by health professionals as needing support due to a risk of choking we saw this was not always given in line with the recommendations in their care plan and this placed them at risk of choking on their food. We saw one person was at risk of choking was supposed to be supported by staff and prompted to eat slowly. We observed this person during three meals over two days and saw they were only supported by staff during one meal. We observed they were eating very quickly and putting large amounts of food into their mouth. This was unobserved by staff and posed a risk of the person choking.

In the third smaller house there was a much better system for nutrition, with staff being allocated a budget and doing the shopping and cooking with the people who used the service. We saw this worked well and the meals being given matched the diet plans people had in place.

We saw people were being supported to attend health appointments and staff were arranging for a range of health professionals to visit people regularly. People were also supported to visit their doctor for annual health checks. One person was supported to go for tests at the doctors on the day of our visit. This meant people were supported to attend appointments to monitor their ongoing healthcare needs.

Requires improvement

Is the service caring?

Our findings

We asked people who used the service if the staff were kind and caring to them and people mostly said they were. One person pointed to a member of staff and said, "She's alright her. I trust her. She's my mate." However two people commented that staff could be a little, "Moody" and "Short" with them. Another said, "I do not like the way they (staff) speak to me sometimes."

We saw some examples of staff being very kind and caring to people who used the service and instances where staff sat with people and supported them with a meal, having a chat with them and involved them in interaction. One person became anxious and a member of staff who knew the person well was very quick to reassure the person and distract them by asking about one of the person's favourite television shows.

However at other times there was a lack of engagement when staff supported people. We observed lunch on the first day of our inspection and we saw staff stood over people to support them to eat which some people could find imposing. There was very little verbal interaction and in some cases none at all. This did not support involvement of people or enable staff to make the mealtime a social occasion.

On the day of our visit we saw one person who liked to lie on the floor during the day. There was a care plan in place informing staff that they should make sure an activity mat the person used was underneath them and kept clean. We observed this person for several hours and saw they were not lying on their mat, they were lying on a hard wooden floor. The mat was on the floor beside them and was very dirty. Staff did not recognise or respond to the discomfort this may cause the person and did not address this until we spoke with the registered manager.

Staff we spoke with had a good knowledge of people's likes, preferences, however we saw some bedrooms were not personalised to people's likes and dislikes. We also saw ill-fitting and creased curtains in some bedrooms. One member of staff told us there had not been curtains up in one person's bedroom. They told us they had found some and put them up, but they did not fit well. Many bedroom doors in the main house did not have the person's name on or any form of personalisation to show this was the person's private space. Bedding throughout the houses was worn and in some cases dirty. The lack of personalisation and a lack of care and attention to fittings did not support people to have a sense of ownership of their personal space and did not create a homely environment for people to live.

People were not always supported to maintain and build on their independent living skills. We saw in one of the houses that staff had a system for people to choose their meals, go out with support from staff and buy the food and then to cook their meals. This provided people with the support they needed to maintain their choice and independence. However in the main house and the other houses, staff drew up a list of what was food was needed and the registered manager ordered the food to be delivered. Although people were supported to take part in baking, they were not routinely supported to develop their living skills by planning, shopping and cooking meals with the support from staff.

In one of the smaller houses we saw evidence that good relationships were in place with some staff and people who used the service. There was an obvious rapport and understanding. We observed individual support being given to people who used the service and staff were interacting in a proactive way by the use of games which had the impact of engaging people and creating a calm atmosphere. We saw people were being supported to make choices about how they spent their day and one person told us they were going to choose a cinema film to watch. However we did not see this type of proactive engagement in all of the houses.

We observed one person who was being supported by a member of staff. The person was not able to communicate their wishes but the staff member seemed to understand what the person wanted and the person responded well to the staff member.

We saw staff were respectful when they spoke with people who used the service and staff were mindful of people's privacy and dignity when assisting them with personal care. However we saw people's dignity was not always maintained. We saw one person who had trousers on which were too big and kept slipping down. This was not addressed until the afternoon when the registered manager noticed and fetched the person a belt. Prior to our inspection we received concerns about people wearing ill-fitting clothes and wearing other people's clothes. We discussed this with staff during our visit and we were told

Requires improvement

Is the service caring?

this was because some of the houses did not have their own tumble drier or washing line and clothing had to be sent up to the main house laundry and this caused items to get mixed up.

We had received concerns prior to our visit about people being in dirty clothes and we observed this on the day of our visit. It is undignified for people to wear other people's clothing or to wear dirty clothing.

The manager told us that there was one person currently using an advocate and two other people who had recently used one. They also told us they had worked hard to trace a long lost family member for one person who used the service who had no other family. They told us this had resulted in a positive impact for the person. This meant people were supported to have access to an advocate if they needed one. Advocates are trained professionals who support, enable and empower people to speak up.

Requires improvement

Is the service responsive?

Our findings

People's healthcare was not properly assessed and planned for as the provider had a lack of systems in place. Staff raised concerns that people's care plans did not match the needs of people who used the service and we found this to be the case in the plans we looked at. Information about people's health needs were difficult to find and often we needed to look at several records to find the information needed. We also found plans did not always reflect people's needs. For example the care plan of one person stated they could walk with a mobility aid but this person could no longer walk and used a wheelchair to mobilise. Another person who didn't have any verbal communication was displaying a new behaviour which staff had not recognised could be a way of communicating pain or discomfort and had not assessed this or sought healthcare advice.

Where people were at risk of developing or had a pressure ulcer, there was a lack of management to reduce the risk and prevent pressure ulcers. Two people had a care plan in place giving guidance for staff to reposition them due to a risk or a current pressure ulcer. Both plans informed staff to reposition these two people every two hours and we saw from the records kept that there were frequent gaps in the recording, so it was unclear if people were repositioned every two hours. A third person had a care plan in place guiding staff to reposition them every two hours but this did not happen and staff said there was no need to do this as the person could move around independently.

A fourth person did not have a care plan in place at all despite them having a current pressure ulcer. We observed they were left in their wheelchair all day on one day we visited and by the afternoon they were clearly uncomfortable, and were displaying signs of pain. We asked them what was wrong and they told us, "My bottom hurts." This person was seen by the district nurse on a regular basis and we saw the district nurse had recommended the person be repositioned every two hours. This information had not been transferred into the person's care plan and the senior member of staff we spoke with was not aware of the need for the person to be repositioned and said this was not happening. They told us they thought the pressure ulcer had healed but a visiting district nurse told us it had not fully healed.

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

The manager told us one person had been writing their own care plan and was fully involved in this process. However we did not see any evidence in the care plans we looked at that people had been involved in them and senior staff we spoke with told us people did not get involved in the reviews of their care plans. This meant people were not given the opportunity to have a say in how they would like to be cared for.

Staff and visiting professionals raised concerns with us about the lack of social activity for some people. A health professional and a member of staff told us about one person who had been promised a garden when they first moved into the service, but this had not happened. The health professional said they had been told the service would develop a day service for the person to get involved in but this had not happened and they were concerned about the person becoming isolated.

People were supported to take part in activities and to go out into the community but it was clear this was no regular structure for people to be supported to follow their hobbies and interests. One person said, "I've been to the day centre this morning. We do sewing and exercises." It was clear the person enjoyed doing this. We also saw some people being taken out in the minibus to attend activities in the community. There was a game of bingo in the afternoon and a person who used the service was the bingo caller. We saw in the afternoon there was a film put on the big screen in the activity room and the staff told us this was open to the people who used the service from all of the houses. However there were only a small number of people who attended.

We observed a lack of stimulation for the majority of people, particularly in the main house. We observed people sitting in chairs or wheelchairs without any meaningful activity or engagement. One person sat and played dominoes by themselves and staff did not attempt to engage in the game. On the occasions we saw staff interact with people and their interests this resulted in a positive outcome for people. For example we observed one person who did not get any interaction for over three hours and during this time they were either asleep or passively staring at the wall. A member of staff then sat with this person and interacted with them with items of interest the person had. The change in the person's mood and

Requires improvement

Is the service responsive?

demeanour were obvious with their face lighting up and them engaging in a meaningful way. However these interactions were short and infrequent as staff were focused on the tasks they needed to do.

People we spoke with indicated that they would feel able to speak with staff if they had any concerns. We saw people were reminded during meetings that they should expect to always be treated kindly by staff and if this was not the case they should speak up.

People who used the service could be assured their concerns would be responded to. There was a clear procedure for staff to follow should a concern be raised. Staff we spoke with knew how to respond to complaints if they arose and knew their responsibility to respond to the concerns and report them immediately to the registered manager. We saw there had been four complaints raised and there was evidence the registered manager had investigated the concerns and discussed the outcome with the person raising the concern.

Inadequate

Is the service well-led?

Our findings

Concerns raised with us both prior to and during the inspection showed there was a lack of openness and transparency in the service. Although people told us they felt they could talk to the registered manager if they had any concerns, some staff told us they had raised concerns with the registered manager and provider and that changes had not been made to improve these. One member of staff told us, "I've asked the manager for both support and assistance but it just never happens. Nobody gets any directions. It's just awful."

A high number of staff had left and were leaving employment at the service and we were told this was because staff morale was low, and that some staff had just, "Had enough." One member of staff told us they felt the registered manager listened to them but that her 'hands were tied' and she was prevented from making the changes she wanted to. It was clear that the relationship with senior management had broken down and staff told us things like, "We are lied to" and "I only stay as I worry that they would replace me by agency and that wouldn't be good for the residents."

Prior to and during our inspection at the service staff openly told us of the issues in the service and they were also raising concerns with visiting professionals. It is of concern that staff either did not feel they could raise these concerns within the organisation or felt that if they had they were not listened to. An example of this was a member of staff who reported poor practice in writing to the manager and the manager told us they had not responded to the staff members letter and so the member of staff contacted us. This showed a lack of response to staff who reported poor practice.

We saw staff meetings were not held frequently to get the views of the staff and where meetings did occur some staff told us they did not feel their views were listened to or acted upon. The minutes of the most recent meeting held in May 2015 showed staff had been told what they should and shouldn't do. However there was nothing recorded to show that the meeting had been a two way conversation with staff being given the opportunity to raise concerns or make suggestions. We discussed this with the registered manager and provider and were told a meeting to get the input from staff on why so many staff were leaving and why morale was so low had not been considered.

The issues with staff not feeling listened to had an impact on their morale and showed there was a lack of effective leadership with a high staff sickness rate in the service. We saw up to three staff a day were calling in sick and this had an impact on people who used the service as it resulted in lower staffing levels and a higher use of agency staff.

People who used the service attended regular meetings and the minutes of the meetings showed that people were asked for suggestions on the menu and activities and any improvements they would like to see. However we saw that people's views were not always acted on following the meeting. For example at a meeting held in January 2015 people had asked for outdoor garden furniture to be purchased so they could sit outside but this had not been acted on. At a further meeting two people had asked for shelves to be put up in the bedrooms and we saw this had not been done when we visited. We spoke with one of the people who had requested this and they said, "No I didn't get the shelf. I would still like one putting up."

We saw evidence that an annual client satisfaction survey was carried out in February 2015 and there was an action plan in place detailing what action would be taken to address any concerns raised. In the main the results of the survey were positive about the quality of the care being provided. However one of the concerns raised was about the safety of the environment in the grounds of the service and we saw there were still hazardous areas. The action plan stated the timescale for making the grounds safe was, 'Immediately.'

There was a registered manager in post and the provider had recognised there also needed to be another level of management and so they had recruited two team leaders and an interim manager. However the interim manager and one of the team leaders had not been given an induction when they started working in the service, despite them being tasked with directing staff in the service.

We saw the provider and registered manager were undertaking audits of the environment. However it was evident that these audits were not bringing about improvements. Staff told us that when repairs were needed these were not addressed in a timely way. We saw the environment had deteriorated and repairs were needed in all of the houses. There were no records to show weekly maintenance checks on the vehicles used to transport people who used the service had been completed since March 2015. This had not been picked up by the health and

Inadequate

Is the service well-led?

safety audits. The local authority had discussed concerns about the environment with the provider the week prior to our visit and on the day of our visit we saw maintenance staff had been tasked with starting the repairs needed. It is of concern that the provider allowed the environment to deteriorate until asked by the local authority to make repairs.

We saw there had been an annual audit of the environment completed in January 2015 and this had identified issues with infection control such as the lack of hand washing facilities in the laundry and a lack of foot operated clinical waste bins in some areas. We saw during our visit that these two issues had not been addressed.

We saw there were weekly infection control audits taking place but we found there were still issues with infection control and the cleanliness of the environment. This meant the systems in place to monitor and improve the risk of the spread of infection were not effective.

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

Records we looked at showed that we, the CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was provided without the consent of service users. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed in the service. Regulation 18(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not provided with care and treatment which was safe and met their needs.

The enforcement action we took:
We served a warning notice in respect of this regulation and told the provider they must be compliant with this regulation by 3 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of the service and this led to people receiving care which was unsafe.

The enforcement action we took:
We served a warning notice in respect of this regulation and told the registered provider they must be compliant with the regulation by 3 August 2015.