Potensial Limited

The Croft

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17, 18 and 23 May 2017 and was unannounced. This meant the staff and the provider did not know we would be visiting.

At our last inspection of The Croft in December 2016 we reported that the provider was in breach of the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:-

Regulation 9 Person Centred Care
Regulation 12 Safe care and treatment
Regulation 14 Nutrition and Hydration.
Regulation 15 Premises
Regulation 17 Good governance
Regulation 18 Staffing

The overall rating for this service was 'Inadequate' and the service was placed in 'special measures'. This is where services are kept under review by CQC and if immediate action has not been taken to propose to cancel the provider's registration of the service, the location 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.

Following the last inspection the provider sent us an action plan. At this inspection we found there were some improvements. However, we also found there were further regulatory breaches.

The registered manager was not present in the service during the 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.

We found there were discrepancies between the number of some of the medicines in the home and the records. We could not be reassured people had received their medicines in the way in which they were prescribed.

The service failed to identify and record risks people posed to themselves and others, as well as have in place actions and guidance to support staff on how to reduce these risks. This meant people who used the service continued to be at risk.

People had in place Personal Emergency Evacuation Plans (PEEPs), these plans were available to emergency services to assist them evacuate people from the building. Following concerns we found during the inspection we asked the local fire safety officer to visit the home. They made recommendations to the

staff on how to improve fire safety on the premises.

We looked at staff records and found prospective staff had completed application forms and undergone Disclosure and Barring Service checks. However, we found references had not been obtained for two staff before they had started to work in the service. This meant recruitment checks were incomplete and staff were working in the service without thorough checks on their background in place.

As a result of the home requiring refurbishment, there were shortfalls in cleanliness.

Staff had failed to support people who had lost weight. One person had a low body mass index (BMI) which placed them at increased risk of cardiac arrest. Staff took action when we raised the issues.

We found staff were keen to learn about their role and people's conditions. We found staff had not received sufficient support, training and guidance to enable them to care for the people who lived at The Croft. We found records which were incorrect and other issues within records which staff were unable to explain.

We saw the service did not comply with the requirements of the Mental Capacity Act 2005. Staff did not understand when to use mental capacity assessments and undertake best interests' decisions. This meant people who used the service were making choices when their mental capacity was impaired and no checks were in place to ensure they understood the consequences of their decisions. As a result people were at risk of inappropriate care.

We saw food was freshly prepared for people who were given a choice of menu. Kitchen staff were aware of people's dietary requirements and demonstrated to us how they were able to meet the needs of people who required specific diets.

Staff were caring and well-meaning towards people, however, we found whilst staff told us they enjoyed their work, their lack of understanding of people's needs undermined their caring role.

We looked at people's independence and found some people were able to go out and about and travel independently as they wished. We found people had varying degrees of independence and recommended people's plans were reviewed to promote their independence.

We found assessment information had been gathered by staff into care plans, however, we found staff did not understand some of the information and the implications for people's care needs. Staff had not given due weight to changes in people's presentation and they had not sought appropriate help and support for people. We saw that partnership working between the service and other professionals was compromised as the service did not have in place accurate records which would adequately support any need for further investigation.

The audits carried out in the home failed to address the deficits we found during our inspection.

During our inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. This service remains in special measures due to an overall rating of inadequate at this inspection. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. If the service demonstrates improvements when we next 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.

Following this visit we wrote to the provider to outline our serious concerns about the operation of the service and they supplied an action plan detailing how they intended to rectify the issues. We also met with members of the provider's senior management team at their request, to discuss their intended actions in order to ensure a robust plan was in place, to drive improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were discrepancies in people's boxed medicines which could not be accounted for by staff.

Recruitment procedures had not been followed. This led to staff working in the home without appropriate checks in place.

We found a number of people whose behaviour posed risks to themselves and others. We found there were failures to mitigate these risks and staff had not been given appropriate guidance to help them support people.

Is the service effective?

Inadequate

The service was not effective.

People's hydration and nutrition were not being effectively monitored. One person was found to be at severe risk of health complications due to their weight. Staff were not aware of the impact of their very low BMI.

Whilst staff were eager to learn we found they had not been given sufficient training and support to provide appropriate care to the people living at the home.

We found the service did not meet the requirements of the Mental Capacity Act 2005. Consequently people were put at risk of not receiving the care they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

We found the ability of the staff to care for people was compromised by their lack of training and understanding of people's mental health needs.

Staff were friendly towards people and engaged people in banter.

We recommended staff reconsider people's care plans to optimise people's independence.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans in the service failed to give staff appropriate guidance on how to care for people.

Staff had failed to respond to people's conditions which put them at risk.

People were not involved in their care planning which meant they were not able to state how they wished to be treated.

Is the service well-led?

Inadequate

The service was not well led.

Records held in the service about people's needs and their personal circumstances were not always accurate.

Audits were carried out on a regular basis but they failed to identify the deficits found in the service by the inspection team.

The provider had carried out surveys with staff and people who used the service. The results of the surveys had been collated and the provider had identified actions to improve the service.

The Croft

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.

This inspection took place on 17, 18 and 23 May 2017 was unannounced.

The inspection team consisted of two adult social care inspectors 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.

Before we visited the home we checked the information we held internally about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events or incidents which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners and the local Healthwatch team. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work.

During the inspection we spoke with nine people who used the service. We also spoke with the regional manager, deputy manager, senior carer, five support workers and two ancillary staff.

We reviewed nine people's care records in detail and 10 staff records. We also looked at other records used in the service including medicines records, people's food and fluid charts and staff competency assessments. We looked around the building and carried out observations.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This 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. The registered provider had an action plan in place to improve the service and we obtained a copy during the inspection.

Inadequate

Is the service safe?

Our findings

We talked with people about living in the home. One person said, "I'm fine". Another person said, "I'm quite happy". People spoke with us about the lack of alcohol in the home reducing people's risky behaviour. However, one person told us people had turned to using high energy drinks in the home and they were still kept awake at night.

At our previous inspection in December 2016 we identified that medication practices at the home did not ensure people's safety. Medication administration procedures and systems were not robust and did not protect people living at the home from risks associated with poor medicines management. We also found people did not have medicine profiles which are needed to give details about their allergies and there were photographs missing from people's medicine records for identification purposes. During this inspection we found improvements had been made and documents with photographs were in place in line with the provider's action plan to improve the service.

Staff administered medicines supplied in blister packs safely. We found the way boxed medicines were managed gave cause for concern, as documents did not tally with stock. One person's Clozaril 25mg tablet stocks showed a discrepancy of 52 tablets and for their 100mg tablets, records showed a discrepancy of 30 tablets. We were able to establish that they had definitely missed two days of tablets. Another person had received one extra Clozaril 100mg tablet than prescribed and their records showed a discrepancy of two tablets. It is essential that people prescribed Clozaril do not miss doses, as this can led to rapid deterioration in their mental health and may need the medication to be stopped and re-introduced on a gradual basis. All of the medication boxes recorded both people's medicines were dispensed on 3 April 2017 but the medication administration records (MARs) indicated additional medication had been received in April and May 2017. We discussed this with the deputy manager and asked them to investigate the matter on 17 May 2017. We asked what they had established on 23 May 2017. The deputy manager explained they were unclear about how to check if medicines were being administered in line with the prescription.

During our inspection we saw one person had an accident. This was documented on the person's care records and appropriate medical support had been sought. However, the accident had not been reviewed in the light of the person's fall to assess if any action could be taken to prevent re-occurrences.

Health and safety checks had been carried out on the building to ensure people were safe. These included checks on emergency lighting, fire doors and fire-fighting equipment. People had in place Personal Emergency Evacuation Plans (PEEPS). These were stored in a file in the office known as the 'Disaster bag'. This meant rescue personnel had access in one place to information on how people needed to be evacuated from the home.

Since our last inspection all fire extinguishers had been checked and were found to be in working order. The provider had a fire risk assessment in place which had been updated by the registered manager in 2016. Records showed that in 2015 a fire officer had visited the home and recommended that if the patio doors needed to be locked they could be linked to the fire system and open if the fire alarm sounded. This change

had been made to the patio doors, however, we found the same practice had not been applied to the front door. Staff were still required to unlock the front door to get people to safety. There were two garden gates at the rear of the property, both of which were padlocked. During a fire drill in April 2017 it was discovered that if people left the home via the door to the garden, they could not access the assembly point at the front of the home. Staff explained to us the solution was to put the padlock keys on the office key ring so when they unlocked the front door they could go around the side of the building and let people out of the gate. We were concerned about people not being able to freely access the assembly point and referred the issue to the local fire service. The local fire officer has since advised us they have visited the home and provided staff with guidance to improve fire safety including repairs to internal fire doors.

The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruitment decisions and also prevents unsuitable people from working with children and vulnerable adults. We saw the provider had carried out DBS checks on prospective staff members, who had also been required to complete application forms detailing their previous experience and suitability for the post. Prospective staff members had also supplied the names and contact details of referees. The provider's recruitment policy required two references to be obtained prior to a person been offered a post. We found two staff for whom the two references had not been obtained. In order that the staff could continue to work in the service, references were obtained during our inspection. Vulnerable people may be at risk because proper and full vetting checks about potential new staff's character, competence, experience and skills were not obtained in advance of them starting work.

We looked at the cleaning records in the home and found there were daily cleaning routines required. However, due to the condition of the home and the need for refurbishment, shortfalls continued in respect of cleanliness. We pointed out a missing drain hole in the downstairs shower room and the lack of cleanliness in respect of shower seating. In one person's bedroom we found a malodour. The senior carer made arrangements for additional cleaning. We saw in the health and safety audit in April 2017 one person's chair in their room needed cleaning. The chair continued to be dirty during our inspection. This meant further cleaning was required to reduce the risks of cross infection.

We found that there were failures to mitigate risks. The staff had not recognised the risks posed by people who used the service to others so had not looked at how these could be managed. For example, we found three people had a recent history of anti-social behaviour. One person's behaviour had led to other people being admitted to hospital. One person also had previous histories of serious self-harm and suicidal thoughts. This had been noted on their assessment documents but no risk assessments had been drawn up and there was no information to assist staff in understanding how to manage situations if the behaviours were repeated. In another person's records we saw that a deterioration in their mental health could lead to a re-emergence of risk-related behaviours such as becoming sexually disinhibited, becoming aggressive and starting to self-neglect. The records did not describe at what point any of these changes in behaviour would be deemed of sufficient risk that the person would be liable to detention under the Mental Health Act 1983 (amended 2007) (MHA), or if staff could implement an alternative approach to reduce the risks being posed. Staff were required to contact the public protection unit for one person, however, there was no information available to say why the public protection unit must be contacted. The deputy manager and a senior carer, who had as recently as April 2017 updated the records, did not realise this was in the care record.

We noted that two people had received fines for dropping litter and other low level nuisance offences and had received court summons. There was no information contained in these people's records to show if they had paid the fine or were to attend court. Also no risk assessments or care plans were in place to support people to manage this behaviour and therefore reduce the risk of repeating this behaviour. We found the

staff had not considered that any continued anti-social behaviour may lead to people being targeted by other members of the community.

This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the staff rota and checked the numbers of staff on duty. Staff were constantly busy carrying out tasks. We saw one person required support with their personal care and found on two days in their recent history, they were unable to have a shower as the two members of staff on duty were of a different gender to the person requiring support. This meant one person with a health condition was at risk of not receiving appropriate care.

The provider had in place a whistle-blowing policy which guided staff on how to tell someone if they were worried about something in the service. The deputy manager told us there were no on-going investigations into whistle-blowing.

The provider also had in place a staff disciplinary policy. We were given examples of when the policy had been used. This meant the provider was willing to use the policy and prevent people who used the service from being in receipt of unacceptable staff practices.

There were communication systems in the home including a diary to remind staff of appointments. Staff completed a handover sheet to pass pertinent information from one shift to another, as well as having a communication book to pass messages on to each other.

Inadequate

Is the service effective?

Our findings

One person told us, "It's not fun in here" and "Been here too long." Another person said, "I don't feel relaxed."

Since our last inspection new staff had been recruited to the service. We found new staff were required to complete the Care Certificate. The Care Certificate is a set of national minimum standards that social care and health workers are required to adhere to in their daily working life. Some staff who were new to the service had yet to complete the Care Certificate. As part of their induction they carried out "shadow shifts" which involved shadowing more experienced members of staff to learn how to carry out their role. We found staff had then commenced working on shift without having in place training which supported them to understand and work with people with complex mental health and learning disability needs.

All the staff we spoke with told us that they were supported in accessing a variety of training and learning opportunities. Staff were able to list training they had received over the last year, such as moving and handling, infection control, meeting people's nutritional needs and safeguarding, amongst others. We looked at the staff training matrix and found existing staff had undergone recent training, for example, in medication awareness, emergency first aid, infection control and fluids and nutrition.

We found staff were eager to learn and understand the application of their knowledge. However we found the majority of staff did not have a background in mental health and did not understand certain issues when they arose. Staff had received some mental health awareness training and some condition specific training such as for working with people who had a personality disorder; however, this was not in sufficient depth to enable staff to work effectively with their client group. In one person's records we found staff misunderstood a person's condition and attributed their increased intake of alcohol as a cause of deterioration in their mental health, rather than this being a symptom of them becoming unwell. It was clear staff needed to be provided with in-depth mental health training in order to enable them to work effectively with people. We also found that staff had not received training around working with people who had learning disabilities or in-depth training around working with people who had treatment resistant mental health conditions. It would be expected that if a service specialises in a particular field all of the staff are trained to work in the field and this would be training at advanced level, not just basic awareness training. Senior managers advised us more in-depth training was planned from September 2017 which would last for 32 weeks.

Staff had not received training around the Mental Health Act (MHA) code of practice and therefore did not understand their obligations when people were subject to sections such as a Community Treatment Order (CTO) and conditional discharges. The lack of understanding of the MHA had led to staff believing that a section 117 of the MHA was a means to compel people to abide by treatment plans and remain at the home. This section merely means they are entitled to aftercare so oversight from a clinical team, regular review meetings and their care funded by the NHS. Some people were subject to CTOs and we found that staff had not checked information about the conditions that were in place.

Staff who administered medication had since the last inspection completed a competency assessment on

their ability to administer medication. These however, had been completed by the previous registered manager who the provider found did not meet their expected standard of practice, and a senior who had not had a competency assessment completed on their practice before assessing other staff.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see if the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Only one person was subject to a DoLS but we found a number of people were deemed to lack capacity to make financial decisions, so had appointees and restrictive practices in place, such as having staff with them when they went out. No consideration had been given as to whether people had capacity to consent to living at the home, or agreeing to the restrictions placed on their care. With regard to the one person who was subject to DoLS; the staff had put in place the necessary arrangements to keep the person safe.

We found the staff had received training around the use of the MCA and DoLS but from the application of this in the service it was clear further training was needed. Staff did not understand the requirements of the MCA and were either unconfident or did not have the skills to complete a capacity assessment and apply any learning to practice. All of the people accommodated at the service had a mental disorder or disturbance of the mind that may impact their ability to make decisions, yet this was not explored in relation to the decisions people made. We saw no records to show that 'best interest's decisions were being made, but staff told us that, for instance, people were not given open access to bathrooms as this was in the best interest of one person who was at risk. One person had additional bedroom door restrictions in situ without a best interest's decision in place.

Care records did not prompt staff to record whether relatives held enacted lasting power of attorney for care and welfare, or Court of Protection deputyships and therefore could legally make decisions about individual's care and treatment needs.

We looked at the records of one person with mental health needs. The records showed their needs impacted on their ability to make decisions around the treatment of their condition and they were refusing to follow Speech and Language Therapy team's (SALT) advice to have a soft diet. Staff told us it was agreed that they had capacity to take this potential life-threatening risk, but no formal capacity assessment had been completed. The staff relied on a letter from a GP six months after the original SALT team's advice. The letter said the person had capacity and could eat their preferred choice of food. There was no review in place of the person's condition.

Staff had some basic knowledge around the right of people who were detained under the MHA to make appeals to the Mental Health Tribunal to seek their discharge from the section. However, they did not realise that automatic referrals to the Tribunal would be made if the person did not appeal or that the MHA code of

practice requires staff working with people who are detained to outline their right to make appeal. We found that staff were not aware that people subject to DoLS authorisations also had rights to appeal their deprivation of liberty via the Court of Protection.

We found that for one person their care records indicated that a CTO had been kept in place at a recent review because the person lacked insight into their mental health and thought they were perfectly well and did not need to take any medication. The records showed the person lacked capacity to manage their own finances and when in hospital they lacked capacity to make a decision about the medication. The documents showed this person was in heart failure but had refused to go for a magnetic resonance imaging (MRI) scan. The staff told us the person was able to make their own decision about this, but no formal assessment had been completed. When we asked the deputy manager to review these decisions, they contacted GPs to do this as they did not understand how to complete a capacity assessment. This meant the person was at risk of improper treatment. Following the inspection the provider sent us additional information. The information further confirmed that the person's capacity had not been considered in the decision making.

Staff were trained to use physical interventions with people who displayed behaviours that challenge. They told us that at times over the course of the last few months they had still needed to intervene, but these instances had lessened since the ban on drinking had been imposed. The ban on alcohol in the home had been put in place to help reduce the number of police call outs to the service. The National Institute for Health and Care Excellence (NICE) guidance on managing aggression produced in May 2015 states that, "In any setting in which restrictive interventions could be used, health and social care provider organisations should train staff to understand and apply the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983." We found that staff had some training around awareness of MCA but not detailed exploration of the MCA code of practice or the application of the Human Rights Act when using physical interventions.

Following the inspection senior managers told us they had put in place person centred reviews. However, during the inspection staff were not ensuring people were given the opportunity to review their own care records and consent to the plans of care and proposals contained within care records. We found evidence of multi-disciplinary teams agreeing an approach, such as times for return to the home for people who had capacity, but the person's view had not been sought. Also house rules were imposed on a generic basis and there was no formal evidence that people had signed up to this. For instance at a house meeting people who attended were asked to agree to the no-alcohol policy being implemented. We found whilst there were significant benefits to this arrangement being made at the meeting, there was no recorded discussion on timeframes or what would occur if people did not agree to this proposal. No other consultation occurred and following this meeting all of the people were issued with letters saying the house was now alcohol free as the majority of people at the meeting agreed it would be a good idea. There was no evidence to show people had formally accepted and agreed to the implementation of this blanket policy.

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

We found one person living at the home was subject to a CTO. A CTO is an order placed on a person which is a safeguard that allows the person to be swiftly recalled to hospital if their mental health deteriorates. Occasionally consultant psychiatrists may include the place of residency on a CTO but these are not binding. Therefore only if their non-compliance with any condition can be seen to demonstrably impact their mental health can this be used as a reason for recall. One person was on a CTO, but staff told them they could not leave or even stay overnight at a friend's house because it was a condition that they

remained at the home. They also incorrectly told the person they had to be in the home at a certain time and tell people when they went out because this was a part of their CTO.

We found that staff did not understand the purpose of the conditions of a CTO and that not meeting them could lead to the person being recalled to hospital. Staff were unaware that the conditions they had in place could amount to a deprivation of liberty and if they did it, would be their duty to raise this with the healthcare team.

The service had DOLS checklists in place for all service users, irrespective of whether they lacked capacity to make decisions or not. The templates made no reference to whether people had been found to lack capacity to make decisions. Without capacity assessments in place people were at risk of receiving inappropriate treatment, as DoLS authorisations cannot be used for people who have capacity. Should people be deprived of their liberty when they had capacity, this would be unlawful.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service had a two week menu in place and found fresh food was ordered to prepare meals. People gave us mixed reviews about the food, however, the majority of views were positive. One person told us the food was, "Brilliant." Another person told us how they were enabled to cook their own food and how much they enjoyed this activity. We observed kitchen staff coming around the communal areas to ask people what they wanted for lunch and they were very accommodating and willing to make individual lunches according to people's preferences. Kitchen staff were aware of people's dietary needs and showed us prepared food for people with diagnosed conditions. At our last inspection we found people who were at risk of weight loss and malnutrition. During this inspection we reviewed people's care records and found there were similar concerns. In one person's care plans we found they were to be supported with snacks to prevent weight loss. However, snacks which they may have been offered and consumed, had not been documented over a period of a number of days. We were not reassured that staff had offered the person the snacks they required to avoid losing further weight.

We looked at the home's electronic record which appertained to the Malnutrition Universal Screening Tool (MUST). This showed people's height, weight and BMI at the point when the information was entered onto the system. We noted that one person was described as not being at risk of malnutrition despite losing a significant amount of weight since January 2017. We demonstrated to the staff the use of the online MUST BAPEN tool, which showed the person was at high risk of malnutrition when their weight loss was considered over a period of time. Whilst the staff told us the person wanted to lose weight, their weight loss had not been interrogated in line with their mental health presentation and the possibility of eating disorders. Staff agreed to make an appointment for the person with their GP for a review.

We found one person with a very low body mass index (BMI) that was potentially life threatening. Staff had not recognised the seriousness of having such a low BMI and the consequences to the person. We fed back to the staff on this issue who agreed to take action.

This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with during the inspection told us they had not received regular supervision sessions or had an annual appraisal. Supervision is a process, usually a meeting, by which an organisation provide guidance

and support to staff. During our last inspection we found staff had not received appropriate support through supervision. We saw the service now had a supervision matrix in place and staff supervision meetings were timetabled throughout the year. We saw supervisors had begun to carry out the supervision meetings in line with the plan. Appraisals were being planned and had yet to be carried out.

We saw the service had in place relationships with other professionals. These included GPs, community nurses, Community Psychiatric Nurses and chiropodists. Staff accompanied people to their appointments with professionals and documented the visits in people's daily notes.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were, "Good" and "Alright". One person told us on the first day of our inspection staff were, "Great", but they changed their opinion the next day to "I don't think they [staff] care at all." Another person described staff as, "Brilliant."

We heard banter and laughter in the home. Staff shared jokes with people. We saw people responded to staff with good humour. We saw staff had regular conversations with people throughout the day and enquired as to their well-being. We found staff to be friendly towards people. People approached staff with confidence and were able to ask staff for help and support.

One person spoke to us about having a bus pass which enabled them to go out. Another person cooked their preferred meals which reflected their national identity. We observed people going out independently. We looked at how staff promoted people's independent skills within the home setting. Since the last inspection we found restrictions had been put in place to prevent people from accessing the main kitchen. We found there was a separate kitchen which people could access. Staff explained to us people could make drinks in the smaller kitchen at night, although staff removed the coffee at 11pm to prevent people from drinking too much coffee and staying awake at night. Staff spoke to us about improving people's independence. One member of staff felt people should be supported to be more independent and their rooms should not be cleaned and tidied as much by staff. They told us people would just go out until their rooms were cleaned. This meant people were not being enabled to develop the skills required for daily living.

We recommend people's plans are reviewed with them to maximise opportunities for people to be independent or further develop their independence skills.

Staff knew people's daily habits and were well-intentioned in providing their care. They told us they enjoyed their jobs and were keen to learn. We found staff's ability to care for people and promote their well-being was undermined by a lack of sufficient training and understanding about people's mental health conditions.

We observed staff supported people on a one-to one basis. They talked to people about where they wanted to go and on return helped people talk to the inspection team about their activities. For example, one person retuned and showed us their new clothing purchases.

Staff knocked on people's doors before asking if they could enter. They were polite towards people and gave people choices, for example about if they wanted their room checking at any point in time. We found staff respected people's wishes and their privacy.

We saw some male staff did not feel able to support a female person's personal care to protect their dignity. However, during our inspection we found people were not always treated with dignity. We observed staff weighing people in the dining room area which was accessible to all.

At our last inspection we found there was a lack of information around the home to provide support to people. We saw a notice board had been put up in the dining room which gave information to people about smoking cessation. One person discussed with staff their wish to stop smoking. The staff member offered to make an appointment and help the person discuss their wishes with the local smoking cessation service.

Since our last inspection the service had implemented monthly 'Empowerment Meetings.' These were meetings for people who used the service, and where staff asked for their views. This meant the service had put in place meetings to involve people in the service. One person said, "Nowt gets done [at the empowerment meetings]." We found staff documented in the minutes where people did not attend and the reasons for their non–attendance, including where people had refused to attend because they had nothing to say. We discussed with the staff the reason behind listing why people did not attend. Staff explained they had been asked to demonstrate people were invited to the meeting. We discussed with the staff alternative ways of doing this so people were not shamed by not attending.

At the time of our inspection staff told us that no people living at the home accessed the services of an advocate. They confirmed that if a person required an advocate to support them in decision making, staff contacted their care manager. An advocate is a person who helps someone express their views and ensure their voice is heard.

People's records were stored confidentially either in lockable cabinets behind locked doors or on computer systems protected by staff passwords.

Inadequate

Is the service responsive?

Our findings

Since our last inspection we found work had been carried out to re-write people's care plans. Each care plan had a date of writing, and a sign off date by a senior manager as well as a review date. We found assessment information had been gathered by the staff and they had drawn up care plans based on their existing knowledge of people. However, we found these care plans contained information about people which staff members were unable to explain to us.

NICE guidance for managing aggression outlines the need to involve people in all decisions about their care and treatment, and develop care and risk management plans jointly with them. The guidance states, "If a person is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer." The care records we reviewed provided no evidence to suggest this occurred and people we spoke with told us they were not involved in the development of their care plans.

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

At our last inspection we saw the service had recently introduced 'Positive Behaviour Support (PBS) 'which had yet to be embedded in the service. PBS is a way of enabling people to change behaviours which challenge the service with the support of professionals. PBS requires strategies to be put in place which seek to reduce the likelihood of behaviours of concern occurring should be documented in a plan. Plans will include interventions aimed at increasing person's quality of life, ones that seek to alter the contexts in which challenging behaviours occur, and those which support the development of new skills that serve the same function as the behaviour, or which enable the person to cope more effectively with situations that they find hard to manage. A PBS plan would typically describe and give guidance to staff how to respond to behaviour which challenges the service to minimise escalation and reduce the risk of harm to the person and others. We found in the care files we looked at there was little information in the care records to reflect these requirements. Following the inspection the provider sent us one example of a care plan in existence prior to the inspection and one we did not look at during our inspection. The care plan documented positive behaviour strategies for staff to use when caring for the person.

We also found that staff's lack of understanding around people's mental health conditions meant they did not give due weight to changes in their mental health, and they lacked the knowledge to identify a change. For instance, during our inspection one person's presentation was clearly a different presentation to that described in their care records. In discussion with us they stated that they were being monitored by equipment which was located in fire detectors and staff were listening to them. We established that no CCTV equipment or other such devises were used at the home. We discussed the apparent change in the person's mental health condition with the deputy manager and senior who did not recognise the potential risk this posed to the person's mental health until we explained the implications. They then made a referral to the person's GP but also told us this presentation had not been evident beforehand. However, one of the inspection team noted that when staff approached the person they spoke loudly over them, asked very

superficial questions, told the person they were ok and gave no space or time for the person to discuss their experiences.

We found the staffs' acceptance of one person losing 23kg in four months being an appropriate weight loss for one person and another person's BMI of 15.4 being without risk, indicated that staff were not picking up indicators that people may have underlying health conditions, eating disorders, or weighing equipment may have been faulty. At the time of our inspection there was limited evidence to show that action had been taken to assess these developments, or contact made with external professionals for advice. Staff agreed to look into these issues and take appropriate action. Following our inspection the provider sent us evidence to show that appointments with external professionals to review these people's care needs had been made and attended. However, this evidence also showed that in the case of one person, no discussions took place at these appointments about their rapid and substantial weight loss. This meant that people's health and wellbeing remained at risk.

We found one person used a catheter and the service had in place a fluid balance chart to monitor their fluid intake and output. The chart failed to look at input and output each day and optimise the use of the chart, so staff were not able to review if the person was well. We looked at the person's associated care plan and found this failed to give staff appropriate guidance on what to do. The person's 'Hospital passport' document had not been updated to reflect the person's use of a catheter and stated that they were independently able to go to the toilet. A hospital passport provides information to medical staff should a person need to attend hospital. Another person as a result of having diabetes, was required according to their care plans, to attend regular chiropody appointments; staff were unable to provide evidence of appointments being made and taking place. This meant people were not getting the appropriate support to manage their health conditions.

We found one person's care records were confusing as they asserted the person had both a bi-polar disorder and schizophrenia in their initial service assessment. This combination of disorders was not mentioned in the person's discharge summary from hospital or their Care Programme Approach (CPA) document. CPA is a method of how services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. It was evident from care records held in the service the person experienced psychotic symptoms, which can occur with a bi-polar disorder. However, it is extremely unusual for a psychiatrist to list these two conditions for one person. Normally, if there is a diagnosis of schizophrenia with a mood component similar to that seen in a bi-polar disorder, the person is diagnosed with a schizoaffective disorder. For a specialist mental health provision we would expect the staff to understand this distinction. We also saw in the same person's hospital discharge information, that it stated they had support from the Trust's learning disability team. However, nowhere in their care record documentation could we find any information about their learning disability and how this impacted their life.

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

During our inspection two people went and got their nails done and one had a haircut. One person went shoe shopping and to the hairdressers and said they were "Quite happy." We looked at people's activities in the home. In the dining room there was a sideboard containing some materials for activities - chess set, craft supplies, backgammon, Kerplunk, Jenga, dominoes and playing cards. We observed staff playing cards with people. One of the people who used the service was delegated an activities role. During our inspection the person asked for prizes as they were going to arrange a game of Bingo. One person told us, "There's not much to do but sit and smoke". Another person told us they were, "Bored." When we spoke with the staff

about this person's comments, they told us the person had refused all suggestions they had made. Another person told us they felt they did not get attention and told us, "It's the more disabled ones who get attention." We found during our inspection people were not networked into community resources and the service needed to adopt a social inclusion approach to ensure people were prevented from becoming socially isolated. Following the inspection the provider told us people were networked into the community. They told us, "We have people who regularly attend snooker clubs, Aspire women's group, and local libraries, pamper day events, going out for meals and visiting family members."

The provider had in place a complaints procedure. There were no complaints recorded since our last inspection. Out of the 12 responses to a survey carried out by the provider to the question, "Do you feel able to share any issues, concerns or thoughts about the service and know how to do this this?" three people said, "All of the time", four people said, "Most of the time", three people said, "Some of the time", one person said, "Not very often" and one person said, "Not at all." The provider identified they needed to improve in this area. They re-issued the complaints procedure, and planned to continue with the 'Empowerment meetings' every month for people who used the service.

Inadequate

Is the service well-led?

Our findings

The registered manager was not present in the home during the inspection. The deputy manager had been delegated additional tasks supported by an active regional manager and we saw visits had been made by a senior manager to monitor the progress of the service. An action plan had been put in place to address the findings of our previous inspection, an updated copy was provided to us and we saw actions had been completed.

At our last inspection we found the audits in the home failed to address the deficits we found in the quality of the service, records were inaccurate and not up to date, and notifications had not been made about police call outs. However, it was difficult to determine if the staff or people using the service had themselves called the police. Since the last inspection we found notifications had been made to the Commission in line with legal requirements and the last awarded inspection rating was on display in line with regulations.

Staff were open, honest and transparent in their dealings with the inspection team. They engaged with the team and were eager to learn. They provided support to the inspection and explanations when required. However, conversely this demonstrated staff required further knowledge and expertise to be able to ensure they were meeting people's needs, and were able to demonstrate compliance with the regulatory requirements.

We noted the number of police call outs to the home had significantly reduced. We found there had been a significant change to the atmosphere in the home. The home was much calmer and the number of incidents involving altercations between people and staff had dropped. This meant people were more able to live in a more comfortable atmosphere.

The service had an up to date statement of purpose, this is a document which tells people and their relatives what they can expect from the service. We saw this had been updated by the registered manager earlier in 2017.

We found the service made regular appointments with the GP surgery and had informed a care manager when they were concerned about a person's mental health. However in terms of partnership working we found staff did not use systems in the home to facilitate evidence gathering. Staff did not have the knowledge to understand people's conditions.

We found the culture of the home to be paternalist towards people. This included bathroom doors being locked so people had to ask staff to open the doors to have a bath. Staff explained this was because one person whose bedroom was on a different level was at risk of accessing the bathrooms and was not safe. We found a bath chart in place; on the chart staff recorded when they had offered people baths and when they had refused. We found one person had been prevented from staying overnight with a friend. People's rooms were checked, tidied and out of date food discarded without the person's consent. This meant staff failed to treat people as adults who had the ability to choose and make their own decisions.

We saw the provider had carried out a service user and staff satisfaction survey to monitor the quality of the service. 70 per cent (12 out of 17) of people who used the service responded. We saw the responses had been collated and analysed by the management team. Out of the 12 responses to a survey carried out by the provider, in response to the question, "Do you feel the service is well-led?" five people said, "All of the time", three people said, "Most of the time", three people said, "Not very often" and one person said, "Not at all." The provider stated, "Again improvements have been made here. Consistency is not yet evidenced here and time, monitoring and measuring will be conducted." Similarly the provider noted in their staff survey that the results showed an improvement in the morale in the service.

In the same survey the majority of people appreciated the location of the home and the ease of access to the local community. At the end of our inspection we fed back to the management team a programme of social inclusion which would benefit the people who used the service to ensure they were networked into local community resources.

We found there were regular audits carried out in the service and found whilst staff completed them, they were basic and did not target globally recognised issues such as staff failing to sign for or give medication correctly. Visits to the home had been carried out by a senior manager to perform checks on the quality of service delivered. We found the resultant reports had highlighted tasks that were needed to improve the service. Staff had written, "Completed" against the tasks when they had been carried out. We found the reviews of care records reported to have been completed routinely in recent months by senior managers, had not identified the significant gaps in information and lack of risk assessments.

In the health and safety audit we saw ticks had been put in the boxes to state handrails had been checked. However, we looked at the handrails in the home and found the handrail for a staircase did not extend sufficiently past the top stair. This meant people were not assisted to get safely to the top of the stairs. To the exterior of the property we found the stone steps did not have any handrails to assist people. Wide concrete steps to the uppermost part of the garden did not have any handrails and at the top of these stairs a large conifer tree had grown and blocked the pathway. This showed the provider's health and safety audit was not effective as people's health and wellbeing was put at risk.

We found that the provider had not recognised the various defects in fire precautions at the home. We asked the fire service to visit the home following this inspection. They forwarded to us a copy of the letter they had sent to the provider which listed improvements which were required to maintain fire safety in the home. The improvements included improvements to 23 fire doors at the service.

Records we found in the service had been updated since our last inspection. However, we found significant gaps in the records. For example mental capacity assessments and best interest decisions were not present. Records regarding people's conditions, both diagnosed medical conditions and those appertaining to conditions imposed upon them, were inaccurate. The provider did not keep accurate, complete and contemporaneous records about people, their needs and the care they received.

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