DEAFinitely Independent

# Beech Lodge DEAF-initely Independent

## Inspection report

Beech Lodge
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Tel: 01926337743

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16 May 2017

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19 July 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We inspected this service on 16 May 2017. The inspection was unannounced. At our previous inspection in February 2015, the provider met the legal requirements.

The service is delivered from two adjacent houses, Beech Lodge and Chestnut Lodge. It provides accommodation and personal care for up to 19 deaf younger adults, who may have learning disabilities or autistic spectrum disorder, a physical disability or a sensory impairment. Fifteen people were living at the home on the day of our inspection.

There was no registered manager in post at the service. 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. A manager had been appointed in October 2016 but had not submitted their application to be registered with us.

Deaf-initely Independent is a charitable organisation. It is overseen by a board of trustees who meet monthly and who is the service provider.

There were enough staff to care for people effectively and safely. Staff were aware of the safeguarding procedures and knew what action to take to protect people should they have any concerns. However, the provider and manager had not always followed appropriate procedures to ensure people were kept safe from abuse and avoidable harm. Some incidents had not been referred to the local authority safeguarding team as required by the regulations. Where people's care and support plans indicated a risk of self harm or a risk of harm to others, there were not always risk assessments to inform staff how to support people in a way that minimised those risks.

The provider and manager were not working in accordance with their responsibilities under the Mental Capacity Act 2016 and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had not always been conducted in order to determine capacity levels prior to important decisions being made. People's involvement in decision making had not been recorded, although we were told people were involved in making decisions about their care. Where care plans contained some restrictions on people's liberty, the provider had not considered whether an application should be submitted to the authorising authority.

The provider checked staff were suitable to support people before they began working in the home and completed an induction to ensure they understood their role and responsibilities. There was a training programme in place to refresh staff knowledge and ensure they continued to work in accordance with best practice. However, staff required further training specific to the needs of people who lived in the home, particularly when people could display behaviours that could be challenging to themselves or others.

People had access to specialist services for their physical and learning disabilities and staff made sure they took their medicines safely and as prescribed.

There were friendly relationships between the people and the staff who provided their care and support. Staff communicated with people effectively using different techniques and took time to understand people's individual needs. Staff tried to work in a person centred way and encouraged people to maintain and develop life skills. However, some of the procedures within the home did not always support person centred care.

Care plans reflected how people would like to receive their care, and included personal information, health needs, preferences, and daily living tasks. However, some care plans had not consistently been updated.

Staff were responsive to people's social needs and encouraged them to participate in social events and activities that were meaningful to them.

Systems to monitor the quality of care to people were not consistently effective. The provider had not always followed the latest regulations in line with the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. They had not managed safeguarding issues appropriately and people's capacity to make decisions had not been assessed. The governance of the home was not always effective and needed improvement.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

The provider and manager had not identified that some incidents in the home presented as potential safeguarding issues. Appropriate procedures had not always been followed to ensure that people were kept safe from abuse and avoidable harm. Where care plans indicated a risk of harm, there were not always risk assessments to inform staff how to support people in a way that minimised those risks. There were enough staff to care for people effectively and safely. People received their medicines as prescribed from staff who had completed training in safe medicines management.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Mental capacity assessments had not always been conducted in order to determine capacity levels prior to important decisions being made. People's involvement in decision making had not been recorded. Care plans contained some restrictions on people's liberty and consideration had not been given as to whether an application should be submitted to the authorising authority. Staff received training to meet people's basic care needs, but needed further training specific to the needs of people who lived in the home. People's nutritional needs were met and they had access to specialist services for their physical and learning disabilities.

### Is the service caring?

**Good**

The service was caring.

People had established friendly relationships with staff and felt cared for. Staff took time to understand people's needs and promote their independence. Staff treated people with dignity and respect. Relationships and friendship that were important to people were maintained. Staff promoted equality and diversity within the home.

### Is the service responsive?

**Requires Improvement**

The service was responsive.

Staff were responsive to people's personal and social needs. They knew people well and supported them to participate in social events and activities that were meaningful to them. Some processes in the home did not support staff in delivering person centred care. The complaints procedure was not available in an easy read format but people told us they would not hesitate to raise any concerns.

## Is the service well-led?

**Inadequate**

The service was not well-led.

Systems and processes were not in place or operated effectively to ensure quality was maintained or identify where improvements were needed. It was not clear how feedback from people was gathered and acted upon. The governance of the home was not always effective as their lack of knowledge of their legal obligations placed people at increased risk. Staff enjoyed their roles and working for the service.

# Beech Lodge DEAF-initely Independent

**Detailed findings**

## Background to this inspection

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

The inspection took place on 16 May 2017 and was unannounced. The inspection was undertaken by two 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 service. The expert by experience was supported by a British Sign Language (BSL) interpreter.

Prior to our inspection visit we had received some information of concern about this service. We therefore reviewed all the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the provider had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. The commissioners had visited the service in February and March 2017 and asked the provider to make improvements in a number of areas.

Before the inspection visit, the provider completed 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 PIR had been completed and gave detailed information about the service.

We spoke with six people and four relatives about what it was like to live at the home. We spoke with four staff about what it was like to work at the home.

We spoke with the manager, the office manager and a member of the board of trustees who was the nominated individual about their management of the service. The nominated individual is a person designated by the provider as legally responsible.

We observed care and support being delivered in communal areas. We reviewed four people's care plans and daily records to see how care and treatment was planned and looked at a selection of medicine administration records.

We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

Whilst people told us they felt safe and happy living at the home and there were procedures to protect people from abuse, we found the provider and manager did not fully understand their obligations under safeguarding procedures when concerns were reported to them. Through talking with staff and looking through records, we identified an incident that occurred on 12 May 2017 which had potential to cause significant risk to both people involved. We also identified two further incidents that occurred on the 14 November 2016 and 10 March 2017 when there were physical altercations between people living at the home. None of these had been recognised as potential safeguarding issues. Appropriate procedures had not been followed to ensure that people were kept safe from abuse and avoidable harm. The incidents had not been referred to the local authority safeguarding team for an independent investigation so any risks could be reviewed and managed to ensure people's needs were met. The incidents had been viewed as part of peoples' behaviour rather than considering the impact on them and others. We requested the manager to make an immediate safeguarding referral in respect of the incident on 11 May 2017.

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

Risks to people's health and wellbeing had mostly been identified, and management plans to minimise the risks had been put in place. However, we found some people's care and support plans indicated they were at risk of self-harm or a risk of harm to others. There was not always evidence of risk assessments to inform staff how to support people in a way that minimised those risks. For example, one person's care records showed they had required hospital treatment twice in the previous six months after they sustained self-inflicted injuries during a period of challenging behaviour. In the person's care records there was a lack of information for staff about how they should identify and manage the triggers for such behaviour, how they could minimise the risks to the person and others, and how and when they should intervene if the person became agitated or aggressive.

Two people were at risk of falls because of their health condition and physical disabilities. Both people had received medical treatment because of degeneration of their knee joints which could further impair their mobility. Neither had been assessed for a risk of falls and there was no information in either of the people's care records detailing how staff should support them or minimise the risks of them falling.

We also found a lack of risk management plans for people who may not fully understand the consequences of their actions. For example, one person had recently been involved in an incident in a local shop. Although this had been discussed in a staff meeting, this had not been translated into a risk management plan to ensure staff had a consistent approach to supporting the person in the community whilst ensuring their safety.

Some people were in relationships with others. One staff member explained how they had supported a person within their relationship. They told us, "I rang the learning disability nurse and they do a workshop and it is all about relationships, safe sex and boundaries. Each week they have a different topic and they

have a portfolio and they build on it." However, there was no reference to this in the person's care plan. There was no information in risk assessments and care records regarding people's sexual behaviours and how staff should support people to maintain and develop personal relationships in a way that promoted their independence, but kept them safe from physical or emotional harm.

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

People told us they felt safe living at the home. Relatives all said their family members were well looked after and safe living there and they had never had any concerns. One relative told us, "I feel [person] is very safe in the home and always have." Another relative said they were confident that if their family member did not feel safe they "would tell me right away." During our visit we saw that people looked relaxed and comfortable around staff.

The manager explained that during the day staffing levels were planned around people's needs and their daily activities. We saw there were enough staff to care for people effectively and safely during our inspection visit. Staff were available at all times in the communal areas of the home. In addition to care staff, the manager and office manager were available to cover care duties if required. Staff told us they were confident there were enough staff to keep people safe, but there were occasions when they felt pressured or rushed. People told us that if they called for assistance, staff responded quickly.

At night there was a 'sleep in' member of staff in each house who people could call on in an emergency. However, we noted that one of the incidents between people had occurred during the night when there were no staff awake to supervise or monitor them. We shared our concerns with the manager who said they would review the situation.

The provider checked staff were suitable to support people before they began working in the home. This minimised risks of abuse to people. For example, Disclosure and Barring Service (DBS) checks, identification checks and references were sought prior to the employment of new staff. The DBS is a national agency that holds information about criminal records.

We looked at how medicines were managed and administered. Staff who administered medicines had received specialised training in how to give people their medicines safely. This included checks on their competency to give medicine and regular refresher training.

Each person had a medication administration record (MAR) that documented the medicines they were prescribed and when each dose should be given. MAR records contained a photograph of the person so that staff could ensure medicines were given to the right person. Daily checks were undertaken by staff to check people received their medicines as prescribed.

Some people received medicines that were prescribed on an 'as required' (PRN) basis, such as pain relief. This meant the medicines should only be given when people were in pain. There were protocols (plans) for the administration of these medicines to make sure they were given safely and consistently.

Medicines were stored securely. However, we found staff had not been instructed to monitor the temperature of the storage area to ensure medicines were stored within the manufacturer's recommended limits so they remained effective. We brought this to the attention of the manager during our inspection visit and they assured us temperature monitoring would be put in place immediately.

There were systems to support people in the event of an emergency. Assistive technology above doors flashed different coloured lights to alert people's attention. One person explained to us what the different colours meant. They told us, "Red light flash is fire and we go out of the building to the front. Orange light is front door and white light is we need assistance."

A fire risk assessment had been developed and personal Emergency Evacuation Plans (PEEPS) had been implemented. These were kept in a separate, easily accessible file in each house. This helped to ensure that the emergency services could assist people to vacate the home in a safe manner, should evacuation be necessary in the event of an emergency.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found that mental capacity assessments had not always been undertaken to see whether people could understand the decisions they were being asked to take. For example, we were told that people did not have capacity to manage their own finances and had signed forms to consent to managers supporting them with their finances. There were no records to show how the provider had decided people could not make decisions about their finances, and there was no assessment about whether people had the capacity to consent to another person managing their money.

Staff told us people had the capacity to make their own day to day decisions. However, this was not being consistently demonstrated. For example, we were told some people had capacity to take their own medicines, but were not able to open all of their own post. People were given family letters to open, but anything official such as bank statements was opened for them. We could not see any records to show whether people's capacity in these areas had been assessed.

People's involvement in decision making had not been recorded, although the manager told us people were involved in making decisions about their care. For example, records showed one person had their cigarettes rationed. There was no evidence as to whether the person had been consulted about the decision, had a part in the decision making process or whether this was a decision that had been made in the person's best interests with the involvement of all those involved in their care.

We asked the manager about one person and whether they had capacity to make their own decisions. The manager told us they did. However, when we reviewed this person's care records we found the provider had written to the person's parents asking for their consent to take the person's photographs. This letter had been sent to the relatives of everybody who lived in the home and did not respect people's right to make their own decisions.

Where people could make unwise choices and decisions because of their social or emotional needs, actions had not always been taken to protect them. For example, it had not been recognised that a person's capacity to understand and assess the risks to their well-being could fluctuate according to their emotional and physical health at that time. This meant both the person and others could be placed at risk because there were no plans to inform staff when they needed to provide guidance to the person in their best interests.

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

The MCA requires the manager to review people's care needs to assess whether people are being deprived of their liberties. The care records for one person showed they were not free to leave the house without the supervision of staff. In February 2017, when the person tried to leave the home alone, staff had prevented them. A member of staff confirmed, "[Person] is not able to go out alone. We have been informed he is not to go out on his own." A mental capacity assessment had not been carried out to establish if this person had an impairment of the mind that might affect their capacity to make decisions in relation to leaving the building. There had been no assessment as to whether this person's liberty was being deprived because they lacked capacity to make some decisions about their care and treatment.

We identified other care plans which contained some restrictions on people's liberty that meant the provider should have considered whether an application should be submitted to the authorising authority. For example, one person had to be continually supervised in the kitchen area and another person had their pocket money monitored.

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

Staff had not received training in the MCA or DoLS. However, staff gave examples of applying the principles within the legislation to protect people's rights. For example, asking people for their consent and respecting people's decisions to refuse support where they had the capacity to do so. One staff member explained, "They make their own decisions. They live fairly independently and we are here to guide them as to whether it is the right decision or not."

Relatives felt staff had the right training to understand and care for their family member. One relative told us, "I have never seen anything wrong."

The provider ensured when staff started work at the home they had training to support them in meeting people's needs. New staff completed an induction to ensure they understood their role and responsibilities. The induction included training in all areas the provider considered essential and a period of working alongside more experienced staff. The induction was based on the 'Care Certificate' This is a set of minimum standards for care workers and provides staff with a certificate at the end of their induction period to recognise their skills and abilities. New staff also completed a three month probationary period to check they had the right skills and attitudes to support people effectively.

There was a training programme in place to refresh staff knowledge and ensure they continued to work in accordance with best practice. The office manager maintained a record of staff training so they could identify when staff needed to refresh their skills. Training records demonstrated that staff had received training in safeguarding, moving and handling, emergency first aid, fire safety and food safety.

However, staff required further training specific to the needs of people living in the home. For example, staff told us one person who lived in the home had a diagnosis of autism. Staff had not received training in how to support people living with autism. Another person could become upset, distressed or agitated and display behaviours that could cause concern to others and themselves. The provider's policy for supporting people with challenging behaviours was recorded as, "All staff will be provided with the necessary training to reduce the likelihood of a situation developing and how to deal with it should this not be possible to prevent." Records showed that just over 50% of staff had completed training in supporting people with

'challenging behaviours', but most of these courses had been completed in 2012 and 2013 and the training had not been refreshed. Staff felt refresher training would give them more confidence to manage challenging situations, especially as there had been an increase in challenging incidents. When asked if they ever felt anxious one staff member responded, "Sometimes because you don't know. It is always good to refresh, especially with the incidents we have had recently." Another staff member told us, "You get some people who will just escalate it (behaviours) because they are not looking to distract."

All the people we spoke with confirmed they could make their own choices of meals and drinks. A daily menu of the food on offer was displayed in the kitchen areas at the home, so that people could choose each day what they wanted to eat. The menu was in picture format. People were able to choose from a range of options and staff asked people for their food choices before their meal was prepared. People could choose alternative foods if they did not like what was on offer at the mealtime.

We saw people having a lunchtime meal during our inspection visit. The dining room was a calm space where people could enjoy their meal with friends. The mealtime was a sociable experience for people, who interacted with each other using hand gestures and sign language.

People were offered drinks and snacks throughout the day. People could also help themselves to drinks and snacks from the open kitchen areas within the home. Staff encouraged people to do as much as they could do themselves, but were on hand to assist people if they required support.

Records confirmed that people had access to specialist services for their physical and learning disabilities. Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, dietician, psychologist, dentist and optician when required. Notes made about the visits were detailed and provided a good record of any advice provided. However, we were unsure about who took responsibility to follow up on medical referrals when appointments to see specialists had not been arranged. For example, we saw one person had been referred to have a 'leg brace' on the 28 November 2016. No follow up action had been recorded on their care records to state what had happened since that date. We shared this with the manager who was not aware of the referral.

All the relatives we spoke with told us that staff contacted them when their family member was unwell or there was an issue.

Good

# Is the service caring?

## Our findings

People told us they would not like to leave the home to live somewhere else which indicated they were happy living there and with the staff who supported them. Two people told us staff were caring and listened to them. A relative explained they knew their family member was happy because, "If [person] comes to see us, they are always happy to go back."

We saw positive interactions between staff and people. People smiled and laughed with staff and appeared relaxed in their company. There were friendly relationships between the people and the staff who provided their care and support.

Staff communicated with people effectively using different techniques. Staff assisted people by talking to them clearly and using specialist communication techniques such as sign language and electronic devices. We saw staff touched people lightly on their arms or hands to provide them with reassurance. Staff answered people when they requested assistance and explained to people what they were going to do.

Staff told us they knew people very well so they understood what people wanted and took time to understand people's individual signs. One relative explained how their family member used some of their own signs to communicate and could sometimes get frustrated if people did not understand. They told us, "Staff take time to find out what [person] wants and see what they are trying to tell them." The relative told us that even when the frustration escalated, staff would always calm the person and find out what they wanted.

We also saw warm relationships between the people who lived in the home. One person happily supported another person to talk with us.

People told us they were able to make their own choices and decisions about their daily lives. One person told us, "I do what I want to do." During our visit some people chose to spend time in the bedroom during the day, and other people preferred to spend time in the communal areas of the home, for example, in the conservatory area or in one of the three lounge areas. Another person told us they could come and go as they pleased, they just let staff know when they were going out of the home.

People had chosen how they wanted their personal space to be arranged and decorated so they felt at home. One person invited us into their bedroom and told us how they enjoyed living at the home. They had an en-suite bathroom and raised area where their bed was situated and obviously felt proud of their own space. They indicated this with gestures and smiles. They were eager to share with us how they had organised their room, which was filled with personal items, teddy bears and pictures of family and friends.

We asked people if staff gave them privacy. They confirmed they did with one person replying, "They push the bell before coming into my room." A member of staff told us each bedroom had an en-suite bathroom which promoted people's independence and privacy.

People were encouraged to maintain and develop life skills, such as cooking and cleaning and doing their own laundry. There were laundry facilities in each unit of the home for people to use as they wished, and we saw one person making use of it when they carried their clothes into the laundry. In Chestnut, people were able to prepare a lot of their food independently. One staff member explained, "We promote them to be independent. I always encourage them to try to do as much as they can as possible. A lot of it is prompts and reminders. I will encourage residents to peel the vegetables and chop them up." Another told us, "We let them choose what they want to do. For example, cooking, we will ask them if they want to be involved but we wouldn't force them to do anything they didn't want to do."

Staff told us friends and relatives could visit at any time and did not have to ring first. People we spoke with confirmed this. There were a number of rooms, in addition to bedrooms where people could meet their friends and relatives in private if they wished. One person had a particular friend who lived in the other house. They told us they could visit whenever they wanted to.

Staff we spoke with told us that they promoted equality and diversity within the home. Staff had taken the time to consider people's sexuality, and supported people to maintain relationships. For example, staff supported people from the LGBT community.

Requires Improvement

# Is the service responsive?

## Our findings

None of the people we spoke with through our interpreter raised any concerns about their care and support. During our visit we found staff were responsive to people's personal and social needs. They knew people well and supported them to participate in social events and activities that were meaningful to them.

The provider information return (PIR) completed by the provider told us: "We provide person centred care in a model framework that allows staff to respond to individual service users' needs. All our service users have individual care plans which are reviewed periodically and up dated accordingly."

We looked at four people's care plans. These reflected how people would like to receive their care, and included personal information, health needs, preferences, and daily living tasks.

Staff kept daily diaries for each person, which recorded their personal care, what they had eaten, any activities they had participated in and information about their emotional wellbeing. Staff told us they had a handover meeting at the start of their shift which updated them with people's care needs and any incidents since they were last on shift.

During our conversations with staff it was clear they tried to work in a person centred way. They understood that people should be treated as individuals and that the more they knew about a person, the better equipped they were to understand them and provide for their individual needs.

However, we found that some of the procedures within the home did not always support person centred care. For example, at night there was a sleep-in member of staff in each house. Although staff told us this was enough staff, it meant people could not always do what they wanted to after 10.30pm. One member of staff told us the sleep-in staff members went to bed at 10.30pm and went on to say, "If the residents want to stay up to midnight or after that we have been told it would have to be in their rooms because they can't be left downstairs, and there is no reason not to be in their rooms because they have got TVs and kitchenettes." This member of staff went on to say they thought people should have the choice, but understood the need for them to be kept safe. Another staff member told us they tried to be flexible, but if they were on duty at 7.30am the next day, they needed to get their sleep. They told us, "Nine times out of ten the residents will normally go to their bedroom. Last week I said they had to go at 11.30pm."

People were offered regular opportunities to pursue their interests and hobbies, both inside and outside the home. One member of staff told us how they did cooking with people and ran a sewing class. On the day of our visit, some people enjoyed taking part in a cooking activity in one of the communal kitchen areas. Staff interacted very well with people during the activity and people clearly enjoyed being involved in the task of cake making and with the cakes they produced. Some people were particularly interested in gardening, and we saw an area where they were growing vegetables and herbs.

Some people's interest was in playing electronic games and gadgets. There was a computer in the lounge area which was freely available for anyone to use.

Other people enjoyed pursing their hobbies outside the home. Some people went horse-riding and swimming and another enjoyed going bowling with friends who did not live at Beech Lodge.

People were encouraged to maintain their social links with friends and family. They attended a variety of clubs in the local area which offered them opportunities to socialise, try new activities and develop new interests.

Each year people were able to go on a holiday of their choice. One staff member told us how they had taken two people on holiday to Spain one year.

We were shown a copy of the complaints process but this was not in an easy read format for people who had limited reading skills. People we spoke with did not know how to make an official complaint, but indicated they would not hesitate to raise any concerns. One person told us, "The residents were angry and arguing. I told staff and they helped." At that moment the manager walked past. The person pointed at the manager and said, "It was him who helped." The last formal complaint had been received in 2015.

Inadequate

# Is the service well-led?

## Our findings

The manager had been appointed in October 2016 and had previously worked at the home as a care worker for ten years. At the time of our inspection visit, the manager had not submitted their application to the CQC to become the registered manager. The manager was supported in their role by a Board of Trustees. We found that improvements to the management of the service were required because shortfalls we found during the inspection had not always been identified and acted upon. Effective systems were not in place to enable the provider to identify where quality and/or safety were being compromised so they could respond appropriately without delay.

Where risks had been identified, measures had not been introduced to reduce or remove the risks. For example, some care records demonstrated that some people were at risk of self-harm or harm to others. There were no risk management plans to inform staff how to manage these behaviours to keep people or staff safe.

There was a system in place to record accidents and incidents, although this was not always effectively implemented. For example, we found inconsistency in how accidents and incidents were recorded. Some were completed on the computer with information on the action taken and any future or preventative action. Others were recorded by hand on plain paper. When we looked through the accident and incident folder, we identified the records for some incidents staff had told us about were missing. Some missing records were able to be printed off the computer, but a handwritten record of a serious incident could not be located. The manager told us they reviewed any reports they received to ensure appropriate action had been taken to manage any individual risks, but this could not always be evidenced. We could therefore not be sure the manager had considered the root cause of each incident and identified ways to prevent the incident re-occurring. There was no overall analysis of accidents and incidents to identify any emerging trends or patterns to inform risk management or identify any learning needs.

The provider had not followed the latest regulations in line with the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. For example, the Care Act expects providers to work within a very definite set of mandatory requirements around adult safeguarding and the Mental Capacity Act 2005. The provider had not managed safeguarding issues appropriately and referred them as required to the local authority safeguarding team. People's capacity to make decisions had not been assessed to ensure staff were acting in the least restrictive way possible and always acting in people's best interests.

Systems to monitor the quality of care to people were not consistently effective. For example, care plans and risk assessments had not been effectively audited. One person's care plan stated they needed two staff members to support them when being transferred from one place to another. The manager told us the person was able to transfer independently. Another person's medicines care plan had not been updated to reflect a change in the medicines they were prescribed. In another care plan it indicated that staff should search people's belongings if items went missing at the home. The manager assured us this was not the case and the way the instruction had been phrased was misleading. Checks of care plans had not identified these errors.

Whilst walking around both homes, we did not see any window restrictors in place. Windows opened wide and so could potentially be a hazard to people who lived in the home. Steps within the homes were not marked or painted and could prove a hazard to people with visual or mobility issues who lived there. The provider had not taken adequate action to minimise the impact of these risks to people.

The nominated individual informed us that the trustees visited the home regularly and spoke with people and staff. The trustees did not record the outcome of these visits and the manager had not received any written feedback from the trustee visits. This meant there were no formal records to provide an audit trail of actions taken to address any issues identified by the trustees. This demonstrated that the governance of the home was not always effective and needed improvement.

People were not asked for their opinion or involved in how the service performed. We were told meetings for people who lived in the home used to take place, but had been stopped in 2016 as it was felt it was more beneficial to talk with people individually. The last survey or questionnaire to people and relatives to ask their views of the service had been sent in 2015. There were no formal records of any discussions with people and it was therefore not clear how feedback from people was gathered and acted upon.

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

Staff told us they enjoyed their roles and working for the service. A typical comment was, "I love it, I couldn't ask for better service users to support."

Staff spoke positively about the new manager, but felt there had been challenges during the transition period between the previous manager and the new one. One member of staff explained how they had not felt valued at the time because they were not aware the previous manager was leaving. Another staff member commented, "It has been difficult at times, but you get used to it. In some ways it has been good for me because I have had more of a challenge and I have had more responsibility." A third told us, "[Name] is the new manager. It is always difficult when things change. People are settling into roles and getting used to new management."

Supervisions are formal meetings between staff and managers and provide them with an opportunity to discuss their role, training and developmental needs. We received conflicting information about how often supervisions took place. A manager told us they took place monthly, a staff member told us, "Every three months we have supervision." However, staff told us they felt supported and found the meetings useful. One staff member told us, "It is useful. If you want to get something off your chest, that is the time to do it."

Staff were invited to attend regular staff meetings. Minutes were taken from the meeting and shared with staff who had been unable to attend so they knew what had been discussed. Staff were able to add any items they wished to raise under 'any other business' at the end of the meeting. Minutes of recent meetings showed items for discussion included the appropriate use of social media, staff rotas and funding for people's holidays.

The board of trustees issued regular memos to staff to keep them up to date with changes in the home. For example, a staff memo had been issued to all staff to inform of them of the manager's appointment.

It is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. When we arrived for our inspection, we saw the provider was displaying their CQC rating from our previous inspection visit when they were rated

good in all areas. An easy read copy of the report was also available which ensured it was accessible to every person who lived in the home.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was not acting in accordance with the Mental Capacity Act 2005. Mental capacity assessments had not been completed when there were concerns that people were unable to consent, and best interests decisions had not been evidenced. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Where care records evidenced a risk to the person or to others, the provider had not always assessed the risk or produced a plan for managing the risk. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider was not acting in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Where people may have been restricted, no consideration had been made as to whether this was a deprivation of liberty that required lawful authority. The provider had not taken appropriate action without delay to safeguard people from the risk of harm. |

**The enforcement action we took:**

We served a warning notice against the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not always have systems and processes to monitor the quality of service or ensure they were meeting other requirements within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We served a warning notice against the provider.