Oakview Estates Limited

Hope House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 March, 4 April, 10 April and 2 May 2017 and was announced. We announced the inspection to ensure the safe running of the service due to the complex needs of people living there. We last inspected the service on 18 May 2015 and found the provider was meeting the regulations we inspected against.

This service is registered to provide care, support and accommodation to a maximum number of 11 people with a learning disability and/or mental health conditions within two separate properties that are next door to each other. When we inspected six people were using the service.

The service did not have a registered manager. The previous registered manager left their employment in March 2017 and last worked at the home in January 2017. A peripatetic manager had supported the registered manager from December 2017 and took over as acting manager when the registered manager left. At the time of the inspection the acting manager was still in place when we inspected the home. The provider had recruited a new manager who was due to start their employment in June 2017. It was then intended the new manager would apply to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the provider had breached five of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These regulations related to; safeguarding service users from abuse and improper treatment; safe care and treatment; need for consent; person-centred care; and, good governance. In particular, there were multiple failures to mitigate risks. The provider had not ensured risks posed to people and others were managed in a manner that ensured safety. Risk assessments had not been completed around the safety of people and staff when in confrontational situations. Physical intervention records showed staff regularly used restraint techniques that were not part of people's care plans.

The provider did not routinely carry out debrief sessions to identify any lessons learnt following serious incidents.

Not all staff felt supported by managers and the provider. Staff were regularly subjected to assaults but there was no evidence available to show the provider had considered how these assaults affected staff member's wellbeing. Records showed they did not have regular supervision sessions and an annual appraisal. We have made a recommendation about this.

We found care records did not always detail how staff should support people when displaying behaviours that challenge. Risk assessments and care plans had not been evaluated or reviewed to reflect people's changing needs. Risk assessments were general and did not provide details of the measures required to mitigate specific risks.

Staff told us staffing levels were insufficient and impacted on their safety. There was a lack of evidence that staffing levels were reviewed and analysed to provide reassurance that sufficient staff were available to provide a safe service. Due to vacancies there was sometimes only one qualified nurse on duty.

New staff had been recruited with no prior experience of the nature of this work. Induction and training was not always effective in ensuring new staff were prepared for the challenges of working at the service. There were also difficulties with staff retention.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. We found restrictions were in place for some people but there were no records to show these had been made following a 'best interest' decision. There was also no record of discussions with people or family members when making decisions on behalf of people. We received mixed views about some people's capacity and whether they understood and were accountable for their actions. We also found no evidence to show the use of CCTV in people's flats had been discussed with the person.

Staff had completed basic training but not always training relating to the specific needs of people using the service, such as training on the Mental Health Act 1983, autism, acquired brain injury and personality disorder. Records showed not all staff were taking advantage of training and support offered by community nurses. The provider said staff were expected to use positive behavioural support (PBS) techniques and training in relation to this was provided during induction. However, one person's records indicated Dialectical behaviour therapy (DBT) a specialist therapy should be used. Staff records showed that staff had also not completed training in this area. We have made a recommendation about this.

There was a lack of oversight from managers of the management of risk within the service. During our inspection visits we requested information to show how incidents were reviewed and analysed. However, this was not readily available when we asked for it. Some incidents of aggression leading to staff being injured had been rated as minor with no internal review having been carried out. Clinical and support staff were not part of meetings to review safety within the service. Minutes of clinical governance meetings suggested areas of risk were not fully analysed, such as staffing levels and skills mix.

Care records were out of date and had not been reviewed to keep up with people's changing needs. Care records did not also support the effective use of positive behaviour support techniques to pro-actively deal with behaviours that challenge.

Staff felt communication was not effective to ensure they had the information they needed to support people appropriately.

We wrote to the provider on 13 April 2017 about the serious concerns we had. In response the provider

supplied us with a robust action plan detailing the action they planned to take to improve the management of the use of physical interventions and to review people's care records. The provider then proceeded to consistently supply a weekly progress update to ensure close monitoring of the outstanding actions identified to meet the requirements of the regulations.

Relatives said they felt the service was safe and provided a good standard of care. However, staff gave us mixed views about how safe the service was.

We found effective systems were in place to ensure medicines were managed, stored and administered in a safe way. However, improvements were required to ensure that the appropriate guidance was in place about when to administer medicines to be taken 'as and when required'.

Health and safety checks and infection control measures were carried out to help keep the premises clean and a suitable and safe place to live.

People had opportunities to take part in their preferred activities. Each person had their own personal activity timetable which staff told us was followed.

Staff were kind, compassionate and caring towards people using the service even though they often had to deal with challenging situations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had not ensured risks to people's and staff member's safety were mitigated and managed effectively. The provider had not specifically risk assessed the use of physical interventions in people's flats and corridors. Staff used restraint techniques that were not part of people's care plans. Risk assessments contained generic information which did not always address the individual risks relevant to each person.

Debrief sessions were not always carried out following incidents some of which resulted on physical assaults on staff.

Staff said staffing levels were insufficient to maintain their safety and wellbeing. The provider did not adequately analyse staffing levels to ensure appropriate staffing was deployed.

Medicines were managed appropriately. Regular health and safety checks were carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not acting in accordance with the Mental Capacity Act including the deprivation of liberty safeguards. There were restrictions placed on some people with no records available to evidence these had been made following a 'best interest' decision process.

Staff had completed basic training and some specific training in induction but would benefit from more specialist training to enable them to better meet people's needs.

Staff said they felt supported but records showed regular one to one supervision and appraisal did not take place .

Induction and training was not effective in ensuring new inexperienced staff were prepared for the challenges of working at the service.

Is the service caring?

Requires Improvement

People did not always receive the recommended treatment as staff had not completed the required training. Staff were not always accessing specialist support offered by the community nursing team.

Relatives told us they felt people generally received good care.

Staff were kind, compassionate and caring towards people using the service.

Information was made available in various formats to help people understand important aspects of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

When we visited the service evidence was not available to show care records had been reviewed and updated to reflect people's changing needs. However, this was made available to us following the inspection. Positive behaviour support techniques were not used pro-actively to deal with behaviours that challenge.

People had opportunities to take part in a weekly programme of their preferred activities.

Relatives did not raise any concerns about their family member's care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Managers lacked oversight of the impact of risk on people's care and staff morale. Some information requested during our inspection was not readily available.

Incidents where staff had been injured were rated as minor and no internal reviews of these incidents were carried out until we raised this with the provider.

Clinical governance meetings did not include clinical and support staff and areas of risk had not been fully analysed.

Staff said communication was not effective and needed to be improved.

An action plan and regular updates have been provided to the Commission on a regular basis since the inspection in order for monitoring of improvements to the service to take place.	

Hope House

Detailed findings

Background to this inspection

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

On the 28 March the inspection was carried out by two inspectors and a specialist advisor. The specialist advisor was a learning disability nurse with relevant experience of working with people with complex needs. On 4 April the inspection was carried out by two inspectors and a pharmacist inspector. Two inspectors carried out the visits on 10 April and 2 May 2017.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the clinical commissioning group (CCG) and the local Health Watch.

The provider completed a provider information return (PIR) prior to the inspection. 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.

We spoke with one person and four relatives. Most of the feedback we received was from relatives as people using the service had difficulties telling us about their experiences. We also spoke with the nurse consultant, the manager, two nurses and ten support workers both face to face and by telephone. We looked at a range of records which included the care records for five people, medicines records, recruitment records for five care workers and other records relating to the management of the service.

Requires Improvement

Our findings

We found during our inspection there were multiple failures to mitigate risks. In particular, the provider had not ensured the risks posed to people and others were managed in a manner that ensured they, or staff, were safe. For instance, we saw from viewing physical interventions records that people had persistently assaulted staff. On several occasions staff needed to go for treatment at hospital or have time off work to recover from their injuries. Yet the care records we reviewed on our initial visit to the service, and those updated following our subsequent visits, did not clearly set out how staff were to manage these issues effectively in future.

We found risk assessments had not been completed around the safety of people and staff when in confrontational situations. We observed and read that a team of staff were often required to assist in dealing with aggressive outbursts including physical interventions. However, risk assessments had not been completed around the deployment of the response teams or of any environmental risks associated with them undertaking physical interventions in people's flats and communal corridors within the service.

We found staff practices did not mirror people's care plans around the use of physical interventions. The physical intervention records we viewed showed staff regularly used supine restraint (this is where a team of staff take the person to the floor on their back). This was not referenced in the original care plans we reviewed. When we revisited this on 10 April 2017 staff had updated the care plans but they still did not always show staff were to use these interventions or that this was the last resort. Also, for some people, care records indicated the physical intervention was not to be used, or this should be in the form of 'seated wraps' only. The physical intervention records for these people showed they had actually been subjected to supine restraint.

We found no evidence of an assessment having been carried out as to whether the use of supine restraint was appropriate. Nor was there evidence of coherent oversight from managers to ensure the restraint was only used as a last resort. We also found no information to show that the Department of Health guidance, "Positive and Proactive Care: reducing the need for restrictive interventions" was considered.

Following our visits the provider carried out a full review of each person's physical intervention records to determine if further information was required in the care plans. This was carried out with input from a Maybo training specialist. Through reviews, the provider noted a positive trend in the number of incidents requiring restraint with the number of incidents decreasing.

Staff told us debrief sessions and lesson learnt discussions did not routinely occur. We asked for records of debrief sessions of which the provider could only produce three during our visit to the service. The provider submitted further records of debrief sessions following our visits to the service. Debrief sessions are vital as they allow staff and the person, where able, to reflect on the incident. This includes considering whether anything could have been done to prevent the incident occurring or to improve the way these situations were handled in the future. The lack of such oversight meant the provider had no mechanism to check that physical intervention was used appropriately and proportionately. One nurse told us, "Debriefing at the end of a shift is not at the level I would prefer. I think we need more of a debriefing process."

Staff gave us mixed views about the support available to them. One nurse told us, "Very (supported) at the moment we have [manager]. [Nurse consultant] is helping a lot with the clinical side. A lot of managers are about at the minute." Another staff member said, "I can talk to anybody. I will go to my manager and the nurse in charge." Other staff raised concerns about safety.

On a regular basis people assaulted staff but we found no evidence to show consideration had been given to the impact this would have on staff members' wellbeing and mental health. We were not assured the provider had given consideration to the potential for staff to adopt overly restrictive and abusive practices, particularly when there was limited oversight by other staff and they were subjected to physical assaults and verbal abuse. One staff member told us, "I've been injured and don't feel supported by the organisation. Due to this threat I've asked not to go [to support a particular person] but due to staffing levels have had to. I shouldn't be put in a position to be hurt. The situation at the moment isn't good….Some staff have been seriously injured. Each day is, can I survive another day."

In light of the risks posed to people and staff we wrote to the provider on 13 April 2017 requiring immediate action to review this situation. On 17 April 2017 they provided us with a detailed action plan that ensured these risks had been mitigated and outlined how they would take action to improve the management of the use of physical interventions.

On 2 May 2017 we saw action was being taken to ensure staff, including the medical director, reviewed people's care records to clarify the use of physical interventions. Trainers from the company the registered provider used to train staff in the use of physical interventions joined this review, as well as completing refresher training sessions with staff. We found some of the risks had been mitigated but without a full review of the service the provider could not be assured staff were only using physical interventions when appropriate.

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.

Care records did not always detail how staff should support people when displaying behaviours that challenge. Records showed people who used the service might attempt to self-harm through hitting, cutting or burning themselves and tying ligatures. Some people had attempted to run into oncoming traffic and jump out of first floor windows. One person's care plan suggested that when they tied ligatures staff were to give minimal attention to this behaviour until they took this off. However, the plan did not outline what staff were to do if the ligature was compromising the person's airway or they refused to remove the ligature. Where people ran into traffic the care plans were unclear on the actions staff should take in these circumstances. We found records did not clearly evidence care plans had been reviewed and updated to ensure they reflected people's changing needs. However, this information was provided to us following our inspection visits.

We found risk assessments were extensive and included sections about every aspect of risky behaviour a person may present. However, each section contained exactly the same information about how to manage and mitigate risks. Risk assessments were generic and therefore did not cover the individual risks pertinent to each person. For example, we saw one person displayed physical and verbal aggression towards staff. The strategies to be used to manage those risks were the same in situations where the person interacted with members of the public when out in the community. This meant staff would not be able to determine from reading the assessments the most effective approaches to use for particular risky behaviours.

Risk assessments were not always up to date. For example, we saw handwritten amendments and additions had been made to some risk assessments dated 2016. From reviewing people's daily notes we saw records of related incidents which had not been added to the risk assessment or triggered a review of the assessment. One person's risk assessment was incomplete particularly the section identifying risk triggers and management strategies.

Most staff we spoke with felt staffing levels were insufficient. One staff member told us, "Safety isn't good. Safety for staff doesn't exist. I have concerns about the staffing levels. We are so short staffed, staff don't feel valued. We are repeatedly asked to work overtime or stay on after our shifts. We are fire-fighting, we struggle through shifts. I was on a shift where only two people had intervention training the others were agency or new staff." A second staff member said, "I wonder about staffing levels, it doesn't meet people's practical needs. It's a juggle to make sure people and staff are safe. If staff are supporting people in the community it's difficult to ensure the staffing levels at the house are maintained. One nurse commented, "(Staffing levels) are sufficient, just say sufficient."

We found the provider was unable to evidence the systems for determining if the number of staff deployed at the home was sufficient to meet people's needs and ensure safety. Staff told us they usually followed contractual agreements. For one person the provider deployed an additional staff member over and above the contracted number. However, we found no review of the service as a whole had been completed. For example, response teams had been deployed for two people at the same time but no evidence was available to show this had been factored into the staffing levels. On an evening staffing numbers decreased but records showed the number of incidents requiring people to be restrained did not. No consideration had been given to the impact this decrease in staffing levels would have on the response team's ability to deal with incidents. One staff member commented, "Over here (Hope Lodge) not really (safe). When something happens it (response team) takes a few minutes to come over. Over there (Hope House) you have everyone so it is safe." Following feedback from us and local clinical commissioners the staffing levels at night were increased by one staff member.

At time of the inspection there was often one nurse in charge of the whole site but it was unclear, in light of the levels of incidents whereby people had placed themselves and others at risk of harm, how the provider determined this was a sufficient number of nurses to meet people's needs.

Due to the lack of communal facilities in Hope House and the separation of Hope Lodge, support staff were isolated in people's flats either on their own or in twos. We found the nurse on duty was based in the office with support workers used to provide most of the care and support for people. When we commenced the inspection we found no evidence consideration had been given to the skill mix of the staff team and the experience they required prior to working at the home. However, following receipt of our letter identifying concerns about the safety of people using the service the provider reviewed the mix of staff at the service and ensured more experienced staff were on duty each day. The registered provider did not make a specific requirement that those recruited to work in this service had previously worked in settings where people could be extremely challenging. Therefore, staff were recruited with no prior experience of the nature of this

work. Although induction training was provided we found it did not ensure they were prepared for the challenges that would be presented. One nurse commented, "Some staff didn't know how challenging the service was (when they started)."

It was clear the working environment was having an impact on the provider's ability to retain staff and morale within the team. We heard at least two staff left the service each month. Albeit the managers told us this was unrelated to the staff being assaulted our feedback from staff suggested the constant risk of allegations being made against them and assaults contributed to people's decisions to leave. One nurse commented, "Morale is improving very slowly. We have just had a lot of people (staff) leave. We needed a lot of staff at one go. At one point we were using a lot of agency." Another staff member said, "At the moment we have a lot of agency in because a number have been injured. We have used a lot agency just recently. It got better for a while." A third staff member said, "Morale, it is being worked on and we will get there." A fourth staff member commented, "Staff morale is a bit low due to change of management and residents have been unsettled. It is starting to get better."

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

Staff told us people's individual needs were taken into account when allocating staff to work with people. For example, some people found change difficult and responded much better to the same support. As such staff allocated to them on the morning would remain in place throughout the day to maintain consistency.

Relatives we spoke with said they felt generally the service was safe. One relative told us, "[Family member] gets 24 hour care which I couldn't give them. Yes, [family member] is safe because they get 24 hour care and is not allowed out on their own." Another relative commented, "[Family member] is very well cared for and they are very safe. The service is 100%, the security at the front door is 100%." A third person said, "Everything seems fine, there have been no major incidents. Staff seem to cope quite well."

Medicines were stored safely and securely and access to them was restricted to authorised staff. The home had appropriate arrangements in place for the management of controlled drugs (medicines that require special checks and storage arrangements because of their potential for misuse) and medicines requiring refrigeration, however there were no such medicines being stored at the home on the day of our inspection.

All of the records we reviewed contained a photograph of the person concerned and included their allergy status. This reduces the risk of medicines being given to the wrong person, or to someone with an allergy.

Some people were prescribed medicines to be given 'when required'. We found protocols were not always in place to guide staff on when and how to safely administer these medicines. Whilst nurses could tell us how they would give the medicines, some information was not recorded in detail or specific to individual people. For one person, on two occasions, how the medicines were administered was different to the written protocol. Also staff did not always record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way.

We looked at the current medicines administration record for one person prescribed a medicine that required regular blood tests. Arrangements were in place for the safe administration of this medicine.

Regular daily, weekly and monthly health and safety checks had been completed to help keep the home and specialist equipment safe. This included checks of fire safety, the electrical installation, gas safety, water

safety and portable appliance testing. These checks were up to date when we inspected the home.

We observed all areas were very clean and had a pleasant odour. We saw staff followed effective hand washing techniques at appropriate times in line with national guidelines.

Requires Improvement

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed the requirements of the MCA and the associated DoLS with the manager.

Staff 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. All of the people living 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 each decision made. We found the provider had generic MCA forms, which listed all of an individual's care and contained the same information to show they lacked capacity. The form was photocopied so each care plan could be highlighted to suggest the person lacked capacity in that area of decision making. The forms also listed professionals involved in the MCA assessment process however, records were not signed by those involved to confirm their agreement to the decision. We found the records did not prompt staff to record whether relatives held enacted lasting power of attorney for care and welfare or whether they were a Court of Protection deputy and therefore could legally make decisions about people's care and treatment needs. By the time we concluded our inspection on 2 May 2017 the provider had reviewed and updated MCA assessments for all but one of the people living at the service.

Staff when looking at some people's capacity determined they had the ability to weigh up the consequences of their actions. Therefore people could be charged for damages caused to property or be deemed accountable for their actions when assaulting staff and others. Yet these people were also deemed unable to make decisions around where they stayed, how many staff supported them and whether they had lighters. The rationale for this variation in capacity was not clearly explained. We could not determine why a person should have capacity to understand the complex ramifications of assaulting staff or damaging property but could not make a decision to stay at the service. For example, one person with autism and a

learning disability who was assessed as lacking capacity in many areas of their life was charged a sum of money for damage they had caused to their flat. Staff told us the decision had been made by the MDT. However, there was no supporting capacity assessment in place to determine if the person had or lacked the capacity to agree, and whether the decision was made in their best interests.

Following discussion with a community nurse it was evident there was some confusion over one person's capacity. External professionals believed the person had capacity, whereas care records clearly indicated the person lacked capacity in certain areas of their life.

One person's care records indicated that when they engaged in self-injurious behaviours staff were to give minimal attention to the behaviour. However, for another person they were to intervene using control and restraint interventions, particularly arm holds. When we asked a nurse the reason for the differing approaches and how capacity was taken into consideration they were unsure. We could not find any evidence to suggest capacity in relation to restraint was documented.

We found no evidence in care records to show people had been involved in the development of their care plans or had consented to paying for breakages and having staff accompany them every time they left the building.

CCTV cameras had arbitrarily been fitted in every person's lounge and kitchen. The provider's policy stated people had to be consulted about the use of CCTV and consent to this being in place. If the individual lacked the capacity to consent to the use of the CCTV a best interest decision was to be made. We found no evidence to show this had been discussed with people or that they were made aware they were constantly filmed whilst in their own flat. We found no best interest decision documentation in relation to the use of CCTV.

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

At the time of the inspection, we found people were subject to a DoLS authorisation. However, some of these people posed a risk to others. We found no consideration had been given to the fact that DoLS authorisations cannot be used for the protection of others. We found no other form of legal authority had been sought to approve people's deprivation of liberty because of the need to protect others. We found one-to-one and at times two-to-one staffing was in place to ensure people did not run into traffic, assault members of the public and whilst in the service to allow staff to physically intervene to prevent the person harming themselves or assaulting staff. It was unclear if the registered provider had sought to establish if this deprivation of liberty was legal. None of the DoLS authorisations we reviewed dealt with this matter either in the narrative or via conditions.

At the behest of the visiting professionals and placing authorities, the Court of Protection had been involved in reviewing the suitability of the placement for people and considering if it was the least restrictive option. We found the provider had taken no action to contact the Court of Protection to discuss the legality of the restrictions for other people.

DoLS authorisations were being sought for people who were deemed to have capacity. However, we found people could be subject to exactly the same restrictions and deprivation of their liberty but without applications for DoLS authorisations, as they were considered to have capacity to make decisions. We again found no evidence to show the legality of these restrictions was explored or that individuals were happy to consent to be under constant supervision.

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.

NICE guidance on managing aggression produced May 2015 states, "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 staff had some training around awareness of MCA but not a detailed exploration of the MCA code of practice or the application of the Human Rights Act when using physical interventions.

We found other than nurses, staff were not receiving training on the application of the Mental Health Act 1983 (amended 2007) and accompanying code of practice. We also found not all staff had received more specialised training around working with the specific needs of people living at the service, such as in relation to learning disabilities, autism spectrum disorders or acquired brain injury.

Some training was provided around specific mental health conditions such as emotionally unstable personality disorder (EUPD) but it was clear this needed to be enhanced to enable staff to work effectively with people. For example, when we spoke with the registered nurse she told us she did not know anything about personality disorder prior to a particular person moving in, at which point they received general Personality Disorder training from the provider's Nurse Consultant which was quite "general and broad based". When the person moved in to the service staff received more in-depth training specific to the person from the community nurse working with the person. The nurse told us felt they understood the person's needs and added that supervision (which took place weekly commencing in January 2017) with the person's community nurse was "extremely helpful" for the staff supporting that particular person as it can be quite challenging. We received feedback from community nurses that these sessions were not particularly well attended. However, these sessions were not compulsory for staff to attend. Although the provider was able to provide some attendance records, these were incomplete. They confirmed staff had been allocated 16 hours each month and between January and April 2017 and had used the full allocation of training and supervision sessions available.

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. A registered nurse told us they had managerial and clinical supervision with the same person who was a member of the management team. They said since changes in the management team had been made they felt "much more supported". They described the manager as approachable. The nurse commented they were unsure of the frequency of supervision and added "probably not as often as we should". They went on to tell us an appraisal would be due shortly as they had been in their current post a year. An appraisal had not yet been completed. By 2 May 2017 all staff members had received either a group or individual supervision session.

We recommend the provider reviews the current supervision and appraisal systems in place to ensure staff receive effective support that meets their individual requirements. We also recommend the provider reviews the core training requirements for all staff members to ensure they receive relevant training to enable them to develop the skills and knowledge required to perform their caring role effectively.

Requires Improvement

Our findings

Some people had specific disorders which required particular treatment and management. We asked a nurse about positive risk taking and how this is incorporated into the person's assessment and planning, in line with best practice. The registered nurse was unsure but told us a lot of the information in the people's care plans was information that came with the person from their previous placement or hospital admission. For example, in one risk assessment one of the strategies to minimise risks was to 'utilise DBT (dialectical behaviour therapy) skills'. DBT is a specific type of cognitive and behavioural therapy to help treat borderline personality disorder. When we asked staff if they had any specific training in DBT they told us they did not. They said, "Staff were not trained in this" and they were "unsure what exactly this meant." This meant staff did not have an awareness of this type of therapy to support the person to maintain their skills.

The provider told us staff were expected to use positive behavioural support (PBS) techniques and we found evidence to show staff received training in this approach at induction. PBS is an evidence based approach to supporting people who display behaviours that challenge others. The behaviours that people displayed at Hope House needed very skilled and consistent approaches therefore it would be expected that staff would receive comprehensive training in PBS and this was regularly refreshed. An induction course would only give the outline of the approach and not provide staff with the knowledge or skills to implement these techniques effectively.

One person we spoke with said they were unhappy with the care provided at the service. Support staff were the main carers for these people. We saw they calmly accepted people may have differing and very negative views around how well staff performed and that people would say this to everyone they spoke with. Staff also appeared to tolerate verbal and physical aggression without complaint.

Relatives told us they felt the service provided good care. One relative commented, "It is one of the best places [family member] has been to. [Family member] has a beautiful flat. They have the support of the support workers, plenty of support they have got. [Family member] is doing well." Another relative said, "Overall everything is really good. [Family member] seems quite happy, they are always nice and clean. I have no concerns, so far everything is going okay."

One person told us the staff were skilled at their job and understood what support they needed. We heard how people were supported to be as independent as possible. For example, staff followed positive risk taking so even when people had memory impairments they continued to go out independently or assist in the kitchen.

Every member of staff we observed used a caring and compassionate approach when working with the people who used the service. However, our ability to observe staff practice was very limited as people lived in their own flats and found it extremely difficult to tolerate strangers entering their accommodation.

Relatives confirmed they were regularly updated about their family member's care. One relative said, "[Family member] keeps in contact with us every day. We go and see them twice a week. They all know [family member's] needs from what I can see. They know what they are talking about." Another relative commented, "[Family member] comes to us. Communication is good. We made a time, they phone on a Friday night." A third relative told us communication had been a problem but following a meeting with the provider this had improved. They said, "Yes any problems they phone. They ring on a Wednesday and it does happen. I stated I wanted them to ring to inform me of everything. They rang on Wednesday…. They have changed it. To give them there due they are doing things differently and are listening."

Relatives felt their family members had benefitted from receiving care from staff who knew their family member's needs. One relative told us, "Seems to be the same staff (on duty). They are good with [family member]. They know about their needs. They know if [family member] wants to go out [family member] gets their coat or if [family member] wants a drink they gets their cup." Another relative told us, "They are really good with [family member]. Seeing [family member] now there is a big difference. They can leave [family member] for a short time. They get themself ready for bed. [Family member] is accepting of things, they seem happier. They [care workers] get him out and about."

In addition to the more detailed care plans people had their own easy read 'person centred plans'. These were written in a user friendly way and included pictures. Records indicated people had signed the easy read versions of care plans, even when they were deemed to lack the capacity to make decisions about their care and treatment. The plans provided details of people's likes and dislikes, as well as their hopes and aspirations. These plans would help staff to get to know the person's preferences and an overview of their background. Most of the terminology and language used within people's care plans and daily notes was caring, respectful and easy to follow.

We found information was available in an easy read format. This could be used to help people understand more complex information. For example, consent forms included pictorial cues and easy read language in larger print.

Requires Improvement

Our findings

We found people's care records had been developed by external teams of professionals when people first moved to the service and most had not been updated. Thus they contained information relating to, for example, how a person was in 2015 but no current information about how they had responded to interventions that had occurred since. Staff we spoke with could not outline how people had changed or whether the interventions and approaches they used made any difference. Following our inspection the provider submitted further information which evidenced that prior to our visits to the service people's care records had been reviewed regularly and updated where appropriate. Further reviews had been completed during the inspection process so that all care plans had been reviewed by the time we completed our inspection.

One person's behaviour support plan had not been reviewed within the planned six monthly timeframe. According to their daily notes there had been a significant increase in their behaviours that challenge over the past six months. However, there had been no reviews of their behaviour support plan prior to the planned review date. Another person's physical intervention (PI) protocol was last reviewed May 2016. We saw that during February and March 2017 there had been eight episodes of physical interventions. However, the physical intervention protocol had not been reviewed or updated to reflect these incidents.

Staff told us they followed positive behavioural support (PBS) techniques when supporting people. Although staff recorded the approaches they followed to deal with incidents, care records did not support the assertion that PBS techniques were used. PBS intervention plans typically have multi-components which are built on the findings of assessment and devised in partnership with key stakeholders. Proactive strategies that seek to reduce the likelihood of behaviours of concern occurring should form the majority of any plan. These will include interventions aimed at increasing a 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. We found little evidence in people's care records to reflect these PBS requirements.

A PBS plan will also describe an appropriate and ethical range of reactive strategies to guide responses to incidents of behaviour that are not preventable and which aim to minimise escalation and reduce the risk of harm to the person and others. These should form a minority component of any plan, but play a crucial role in terms of making people safe. We found the plans for supporting people to manage behaviours that may challenge were vague and did not set out clearly what action could be taken to de-escalate situations or

when it would become unacceptable to leave the person to achieve emotional regulation through breaking items. We found the provider had given no consideration to providing safe environments where people could vent their anger.

Finally, PBS plans provide guidance on how strategies will be implemented, by whom and by when. Data-based systems are required to monitor both the reliability of plan implementation and resulting changes in quality of life and behaviours that challenge. At the time of the inspection we found no evidence to show that the managers were monitoring the implementation of plans.

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 the person 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.

People were supported to participate in activities they liked and wanted to do. For example, one person had a full and varied timetable of activities with designated staff support to attend these activities. The plans in place reflected the person's activity timetable. There was also a feedback sheet attached which encouraged staff to reflect on the outing with the person. There was specific step by step guidance for staff in working with this particular person who at times displayed behaviour that challenges. Another person was supported to visit and maintain family relationships. An activity co-ordinator said, "We provide service users with an activity planner each week. We talk to them about dreams and aspirations, such as horse riding. We evaluate activity planners. There is 30 hours of meaningful activity each week. Most people engage with that unless their mental health deteriorates."

Relatives gave us positive feedback when we contacted them about their family member's care. One relative commented, "I have no concerns at all." Another relative commented, "They are dealing with [family member] appropriately. I have no concerns."

Requires Improvement

Our findings

Although, on several occasions we asked for evidence to show that senior managers have reviewed or analysed the incidents to determine the actual level of risk or to identify how the risks could be mitigated, this was not provided. We also asked for root cause analysis and lessons learnt for specific incidents such as when one person broke out of a five to six person restraint and assaulted a staff member. This information was not provided during our inspection visits. This showed the provider did not have oversight of the service.

We found that where staff recorded incidents on the provider's data gathering systems there was no clear rationale as to how the severity of incidents had been rated. For instance some incidents of aggression, which had led to staff being injured and needing time off work, had been rated as minor. Also a senior manager had, without considering specific guidance around supporting people when using cars, taken individuals out on their own, in their car, which was outwith the guidance detailed in one person's support plan. This had only come to light because the community nurses had been made aware of the issue and not because of the systems in place for monitoring the service. This meant the central management team were not always being alerted to incidents so were not initiating their internal review processes. Following the inspection the provider has reviewed the incidents and taken action to reduce the potential for these to re-occur.

We found staff did not follow the registered provider's policies around the management of incidents and governance of the service. The provider operated a system of unit led clinical governance meetings. The terms of reference for these meetings stated, 'The unit led clinical group ensures a robust minuted monthly review of all key safety and risk issues in a service which links clinicians and audit champions clearly and formally into these discussions'. We were concerned to find the clinical governance meetings, where staffing levels and the ability of the home to meet people's needs and risks were discussed, were not completed on a monthly basis as prescribed by the providers own policy. Also, the attendees at these meetings included the manager, head cook, maintenance person and housekeeper. Other than the manager, no other clinical input had been secured for these meetings.

The format used for documenting the discussions that took place during unit led clinical group meetings used questions to prompt an analysis of important issues. For example, in relation to staffing these questions included; 'Do you have the correct skill mix?' and 'Are the staffing levels in your unit sufficient to ensure optimal patient safety and effectiveness'. However, in the minutes we viewed there was usually only factual information about staffing, such as the number of staff and vacancies.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that whilst a system of medicine checks was in place, staff did not always notify the manager when they identified discrepancies so that an investigation could take place. These checks help to identify any issues quickly in order to learn and prevent the errors happening again. The provider also completed monthly medication audits but these were not robust and had not identified the issues we found with 'when required' medicines. Following our inspection the provider updated medicines competencies for all nurses. Nurses had also completed additional medicines management training focusing on medicines stock reconciliation and reporting processes. Medicines audits carried out in June and August 2017 after our inspection identified no issues in relation to medicines stock reconciliation.

Staff told us communication needed improving. One staff member said, "The nature of service users doesn't filter down to us. Care plans may have changed and it doesn't filter down straightaway. Then the service user doesn't want you to do that anymore. We need things filtering down." Another staff member told us, "If anything is lacking it's communication. There are meetings between management and nurses but sometimes we don't get to hear things. We don't get told enough. The clients can say things and I don't know if it's true or not. It could be important on how we support someone but we haven't been told everything."

Staff told us they felt more supported with the current management arrangements. A nurse said since changes had been made to the management team they felt "much more supported". However, other staff said they were not supported by management or the provider. One staff member said, "There are no managers to support us that's what is needed. Staff are leaving because of the danger; we are burnt out both physically and mentally from exhaustion. The nurses and other support staff are fabulous. We support each other at debriefings, after a hard day we hug each other, thankful we have got through another day."

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

We received mixed views about the involvement of external agencies in developing care documents. The manager advised external health professionals completed these which they clarified meant taking the lead and writing individual risk assessments and care plans. We asked for clarification as the documentation contained with care files was the provider's own documentation. However, nurses and external professionals indicated external professionals would participate in developing individual management plans for the particular people they had involvement with but would not take the lead on this. They said they worked collaboratively with the person's named nurse and signed relevant documentation. We could not find any evidence of this in people's records. In one person's records it was recorded a health care professional had declined to sign the provider's documentation. We saw other examples where health professionals had shared their own documentation and correspondence.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people received care that met their individual needs and preferences. Regulation 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the Mental Capacity Act (2005) when people lacked capacity to make some decisions. Regulation 11(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to properly assess and mitigate the risks to people's health and safety. Regulation 12(2)(a) and 12(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that physical interventions to restrain people were used appropriately and proportionately to keep people and staff safe. Regulation 13(4)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems to adequately assess, monitor and improve the safety of the service and to mitigate risks to people's health, safety and welfare. Regulation 17(2)(a) and 17(2)(b).