Elite Care Homes Ltd

Moseley Gardens

Inspection report

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12 April 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 28 March 2018 and 12 April 2018. This was an unannounced inspection.

Moseley Gardens provides accommodation and personal care for up to eight people who require specialist support relating to their learning disabilities and/or mental health needs. At the time of our inspection, there were five people living at the home. At the last inspection in November 2017 the service was rated as Inadequate in four out of the five areas we looked at. At that time, we found that sufficient improvements had not been made since our previous inspection in January 2017 and a further deterioration was noted. The provider was found to be in breach of the conditions of their registration because they had failed to ensure a registered manager was in post. They were also in breach of regulations 11, 12, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to consent, safe care and treatment and good governance, respectively. We imposed urgent conditions upon the provider's registration at this location requiring them to take immediate action to safeguard people against the poor quality and potentially unsafe care that they were receiving at this service. We also proposed to cancel the provider's registration at this location if sufficient improvements were not made. We received representations from the provider against this action alongside an action plan assuring us that improvements had been made since our inspection in November 2017. We carried out this inspection on 28 March 2018 to check whether improvements had been made and to inform our decisions about whether or not to continue with our proposal to cancel the provider's registration at this location.

We found sufficient improvements had not been made a further deterioration was noted; this was namely due to the provider's failing to learn lessons in order to promote and maintain the safety and comfort of people living at the home. We found sufficient evidence to demonstrate a continued breach of regulations 12 and 17 of the Health and Social Care Act Regulated Activities) Regulations 2014 concerning the safety and governance of the service. We also found breaches of regulations 10, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to dignity and respect, safeguarding and staffing. You can see what action we have taken at the bottom of this report.

The provider was required to deploy a Registered Manager to manage the service as part of the conditions of their registration. 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. There had not been a registered manager in post since August 2017. The provider had appointed a new manager who had been managing the day to day running of the service since October 2017 but they withdrew their application to register with us and left the service in January 2018. A further manager had since been deployed to the service and had been in post since February 2018. They had initiated their application to register with us but this had not yet been completed. This meant that the service remained without a registered manager and the provider continued to be in breach of the conditions of their registration. We are in the process of deciding what action we shall take regarding this offence.

The service was not always safe because staff did not know people well enough to recognise or did not always recognise the potential or actual signs of abuse. The provider had not always followed robust recruitment practices to ensure only staff with the sufficient level of skills and experience had been deployed to support people within the home. The provider had also failed to ensure that fire safety practices and the home environment had been maintained to promote peoples safety, privacy, dignity and comfort. The provider had not consistently implemented effective quality monitoring systems and processes which meant they had failed to proactively and independently identify the shortfalls we found during the inspection.

The provider had undertaken a full staff reform, which meant that only three members of staff were still employed by the provider, two of these were night staff. The remaining staff were deployed from an agency. The provider had recently initiated a new staff development programme, but this was still in its infancy and the provider was unable to assure us that staff deployed had the knowledge, skills, training and experience to support people safely and effectively. People were not always cared for in the least restrictive ways possible and the provider had not always treated people with dignity or respect because their privacy was not always maintained and the home environment continued to require improvement.

People were supported to maintain good health because the provider worked collaboratively with other agencies. However, due to the inconsistent staffing team, recommendations made to support people's care and support needs were not always implemented.

The provider had increased the staffing levels within the home which meant people were supported to engage in more activities of interest both in and outside of the home. Staff were seen to engage and interact well with people and people appeared comfortable in the presence of staff. People were encouraged to develop and maintain their independence as far as reasonably possible and were supported to sustain relationships with people that were important to them. Visitors were welcome at any time.

The overall rating for this service remains 'Inadequate' and the service therefore remains in 'special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement has been made within this timeframe and we continue to find a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months of our return visit if they do not improve. After which, this service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will then be conducted within a further six months, and if there is still not enough improvement and an on-going rating of inadequate is awarded for any key question or overall, we will take further action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People were not always protected against the risk of abuse or avoidable harm because staff did not always recognise the potential or actual signs of abuse.

Potential safeguarding incidents were not always recorded or reported to the relevant agencies as required by law.

The provider had not always followed robust recruitment practices to ensure only staff with the sufficient level of skills and experience had been deployed to support people within the home.

The provider had failed to ensure that fire safety practices and the home environment had been maintained to promote peoples safety, privacy, dignity and comfort.

Ineffective medicine management processes meant that the provider could not always be assured that people had received their medicines as prescribed.

Is the service effective?

Inadequate

The service was not always effective.

People's rights were not always protected because systems and practices did not always ensure care was provided in the least restrictive ways possible.

The provider had failed to ensure people received care from staff who had received the relevant training to their jobs safely and effectively.

People were supported to maintain good health because they had access to other health and social care professionals when necessary. However recommendations were not always followed due to the inconsistencies in staff deployment.

Is the service caring?

Inadequate

The service was not always caring.

People's needs were not always met in a safe way and the provider had not ensured that people were cared for in a comfortable environment that protected their privacy or dignity. This placed people at risk of physical and psychological harm.

The lack of consistency in the staffing team meant that people were not able to form lasting and stable relationships with staff, contrary to the recommended needs of people with learning disabilities and autistic spectrum disorders.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Increased staffing levels meant that people were supported to engage in more activities. However, recommendations made by specialist services to ensure that people had structured daily routines had not always been followed.

There was some evidence to show that people were involved in the planning of their care.

People were supported to maintain positive relationships with their friends and relatives.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was not meeting the conditions of their registration because they had not ensured that there was a registered manager in post.

The systems and processes in place to assess and monitor the safety and quality of the service continued to be ineffective.

Despite us notifying the provider of the significant shortfalls that we had identified relating to the safety of people living at the home, they failed to rectify the issues in a timely manner. Placing people at continued risk of harm.

Moseley Gardens

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 28 March 2018. The inspection was conducted by two inspectors. This inspection was planned to check whether the provider had adhered to their action plan and the required improvements had been made to meet the legal requirements and regulations associated with the Health and Social Care Act 2008. We returned for a second visit on 12 April 2018 to follow up on the providers actions to promote the safety and comfort of the service provided to people.

Before the inspection, we looked at the information that we hold about the service prior to visiting the home. This included the action plan that the provider had sent to us to inform us of what improvements had been made at the service. We also looked at statutory notifications from the provider that they are required to send to us by law about events that occur at the home, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we spoke or spent time with five of the people who lived at the home. We spoke with nine members of staff including the manager, a senior carer, a shift leader, four agency members of staff and two apprentices. We also spoke with three visiting health professionals, a member of the local safeguarding authority and two service commissioners. We made general observations around the home and reviewed the care records of three people to see how their care was planned. We also looked at the medicine administration processes within the home. Furthermore, we reviewed training records for staff and at seven staff files to check the provider's recruitment processes as well as safety and competency checks. We also asked to look at records which supported the provider to monitor the quality and management of the service; however the manager told us that many of these had not been implemented and were due to be

'rolled out' in April. This included environmental audits, infection control and medicine management audits as well as monitoring of care records and service user feedback

Inadequate

Is the service safe?

Our findings

At our previous inspection in November 2017 inspection we found that people's safety and comfort were not protected and the service was rated as inadequate. This was because people were not supported by enough members of staff to meet their needs safely and effectively. Staff were not always aware of people's risk histories which put people, staff, visitors and the wider public at risk of the potential for avoidable harm. The provider had also failed to maintain a clean and safe home environment. During this inspection, we found that sufficient improvements had not been made.

We found that the provider had increased their staffing levels in accordance with the conditions imposed upon their registration for this location and in keeping with their action plan. However, the staffing team largely comprised of agency staff. The manager told us that during a staff reform, staff were required to re-apply for their jobs. Out of the staff that re-applied, only two of these were successful at interview and both of these staff members worked nights. One member of staff did not re-apply for their position but was recognised for their skills and experience and was therefore transferred over to a 'bank' (temporary) contract. This meant that during the day, only one member of staff was a regular and consistent member of staff and the other staff were deployed from an agency. The manager told us that they were now starting to get more consistency in the agency staff that were deployed at the service. On the day of our inspection there were eight members of care staff on duty. Only one of these staff members worked for the provider directly. Five staff members were deployed from an agency and two were working at Moseley Gardens as part of their apprenticeship with an adult learning centre. This meant that people were not receiving consistency in the care and support provided to them. Research shows that people with autism and/or other moderate to severe learning disabilities have difficulty adjusting to changes in routines. Therefore people can find inconsistencies or significant changes in care staff stressful and may lead to an increase in challenging behaviours, such as physical aggression and self-injurious behaviours. Visiting health professionals we spoke with who specialises in the care of people with learning disabilities, autistic spectrum disorders and mental health confirmed that this had the potential to negatively impact on the people living at the home. One visiting health professional stated, "[person] needs routine and consistency; it's no wonder their behaviour has changed".

Whilst people appeared to be comfortable and relaxed in the company of staff on the day of our inspection, it was difficult to ascertain the impact that these changes had had on people in recent weeks because records had not been accurately maintained. Information we hold showed us that one person was known to present with behaviours that are often referred to as 'challenging' and that at times this behaviour had led to a pattern of safeguarding concerns which were targeted at specific individuals. During our inspection, we saw an incident whereby this person grabbed the hand of another person who lived at the service. They stated, "Get off, that hurts" and told staff that they 'didn't like it'. Staff we spoke with told us that they had worked at the service a few times over the last three weeks and had witnessed this type of incident several times before. However, records we looked at later in the day showed that this incident had not been recorded and only one other incident dated 19 February 2018 had been recorded. Three other staff we spoke with told us they had not witnessed any incidents between people living at the service and they were unaware of the potential risk factor for this person to target others. Records we looked at stated that staff

were required to monitor this persons behaviour on a 1:1 basis within the home environment and to look out for 'triggers' in a preventative measure. We saw that the person was not being supported on a 1:1 when the incident outlined above occurred and the staff member who was assisting us with our inspection was required to intervene. Further to this, we saw throughout our site visit other occasions when this person was seen to be staring at the other person with an intimidating and threatening manner, which went unnoticed by staff and was not recognised as a potential warning sign for a potential proceeding action or incident. The person who was on the receiving end of this potentially targeted behaviour was seen to be weary of the other person and monitored their movements closely; they were seen to flinch as the person approached them on a number of occasions throughout the day. We fed this back to the manager at the time of our inspection and also raised a safeguarding concern in order to protect the person affected by the incident, as this was considered to reflect physical and psychological harm. The provider had not raised any other safeguarding concerns independently in relation to this or any of the other incidents reported to us by staff. We explained to the provider that they had a legal obligation and a moral duty to protect people from the risk of abuse, including but not limited to physical, verbal, psychological and/or emotional abuse and that people had the right to feel safe in their home environment. This was a continued failure within the service and had been identified at our last two inspections.

This meant the provider was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of the report.

The lack of recording of incidents and the inconsistencies in the recording of people's health and associated risk factors had also been identified at our last inspection and was an on-going issue within the service. This showed the providers failure for lessons to be learnt. For example, we saw that one person was identified to be at risk of self-harm and had a history of suicidal intent. We saw three different records that all provided different information concerning this person's risk behaviour in these areas. The information demonstrated that this person had presented with a number of methods in which they had either attempted to cause themselves harm or with the intent to end their life. The inconsistency and lack of collaboration of this information meant that a full profile of this person's risk history had not been formalised to inform a comprehensive review and plan of this persons support needs. Further to this, we saw that the provider had not recognised the potential ligature risk within this person's bedroom in order to mitigate the risk of potential avoidable harm. This was fed back to the manager and the senior carer at the time of the inspection and this risk was pointed out to them visually upon the review of the home environment. We asked that this risk be addressed as a matter of urgency. However, when we returned on 12 April 2018, we continued to find the ligature risk within the person's bedroom and their risk assessments or care support plans had not been updated accordingly.

At our last inspection, we found that the maintenance and cleanliness of the building required improvement in order to protect the safety and to promote the comfort of people within their home environment. At this inspection, we found that some improvements had been made including the replacement of some flooring and furniture in the dining room as well as re-decoration of the lounge. Some people's rooms had also been re-painted with a colour of their choice and where maintenance issues had been identified, some of these had been addressed for example, a light bulb and toilet seat had been replaced. However, we continued to find the flooring in some en-suite facilities required replacing as these were seen to be separating from the walls with a build-up of mould and mildew in some areas, all of which caused a potential infection control issue. Two people's shower facilities also had large open plug holes without a cover which had the potential to cause injury. Another person's toilet cistern had been replaced but we saw brown stains around the toilet flush. We were told by the senior carer that this looked like the bathroom fitters had used the wrong glue; they recognised that if that had happened in their own home, they would have complained and had it replaced. Another person's bathroom light was extremely dark and the bathroom smelt damp and musty

due to a lack of ventilation. When we pointed this out to the senior carer they found a switch outside of the bathroom, towards the ceiling to activate the fan which had been turned off. Staff were unaware that this was there and it had not been used. We also saw that one person had white vertical blinds in their bedroom, not only did this have the potential to cause sleep disturbance due to the lack of protection from the light, we also found that at least four of the vertical slats were missing. They also had a large window in their en-suite which had the remanence of a set of blinds with only three slats left in situ. This window was not frosted to obscure visibility and the person's privacy was significantly compromised during personal care as it was a front facing window which overlooked the public street and a public park. Another person did not have curtains or blinds in their bedroom. This compromised their dignity and comfort also. This was another on-going issue within the service and further demonstrated the provider's failure to learn lessons as we had identified two other people who did not have any window dressings at our last inspection; which had been replaced at this inspection. Furthermore, we found one person had a sofa in their room which was soiled (on-going since our last inspection) unoccupied rooms had not been properly cleaned and saw rubbish such as used toilet rolls and old toiletry bottles left in the en-suites as well as left over personal effects of previous residents in the wardrobes, amongst other rubbish. Again, these continued issues showed that the provider had not applied this learning or extended it to continuously monitor or improve the wider service or meet the needs of people. Furthermore, we saw that one person's security was compromised because their room was accessed via the back garden and the lock to their door was broken.

In the garden area we saw that the provider had built a new storage space for the rubbish bins. When we asked staff to open this, we saw clinical waste bags piled high in excess of a general waste bin and evidence of a glove on the floor; this evidenced further infection control concerns.

We looked at other records concerning the safety and maintenance of the building including environmental audits and fire safety. We saw that some fire safety checks had not been maintained since the previous manager had left in January 2018. Records we looked at showed that the most recent fire drill was dated 28 December 2017 and other fire safety checks had not been maintained between 04 February 2018 and 04 March 2018. We also pointed out to the manager that the homes fire safety procedure stated that different call points should be checked on a weekly basis, but there was no record of this being done for over a year. We saw an historic fire risk assessment had identified a number of action points but action taken had not been recorded and therefore we could not be assured that these actions had been completed. Furthermore, the fire risk assessment had not been updated since changes had been made to the environment, including the new laundry facility which is considered a high risk area with regards to fire safety. We asked staff including the manager, who the allocated fire marshal was on the day of our inspection. We were told that no-one had been allocated to this role and that staff required fire safety training. We saw that people had personal emergency evacuation plans (PEEPs) within their care files, but these did not always accurately reflect people's needs and not all staff were familiar with these. However, staff we spoke with were aware of where the fire exists were and explained that they would support people to evacuate the building in the event of a fire.

We found that some members of staff were first aid trained, but only if they had sourced the training independently or had received training from a previous employer. We saw a poster in the communal area that identified which staff member had been identified as the allocated 'first aider'. This staff member no longer worked at the service. Staff spoken with were unsure of who was the first aider on duty but referred to the shift leader as the person they would go to in the event of a medical emergency.

We found that improvements were required to the provider's medicine management practices. Poor governance of the medicine administration records (MARs) meant it was not possible to check whether or not people had received their medicines as required. For example, archived MAR's could not be found and

staff had not consistently or reliably maintained stock balances or audited the medicines to ensure that people had received their medicines as prescribed. The stock balances between the number of medicines available compared with those administered did not always add up. A staff member we spoke with said that this was because staff had not always recorded the 'carried forward' amount of tablets from a previous medicine cycle. For example, we found that one person had a box of lorazepam dated 17 December 2017 which indicated a supply of 28 tablets had been provided at that time. There were 21 tablets left in the box out of a possible 28. We also saw a pharmacy delivery page that stated a further box of 28 Lorazepam tablets had also been delivered on 19 February 2018. However this person's MAR charts showed that 0 lorazepam tablets had been administered for the current medicine cycle. We could therefore not account for the missing 35 tablets. We asked to see the previous MAR charts and medicine ordering/check-in records to look at whether we could trace the outstanding medicines. However, these could not be found at the time of our site visit and have not been provided since, as requested. Another person also had a stock of lorazepam tablets. They had two boxes, one full box with 28 tablets and another with 26 tablets remaining dated 07 December 2017. This suggested that two had been administered. There was no record of any lorazepam tablets being administered on the MARs for the current cycle and previous MARs could again not be found. The medicine delivery/ check in form recorded that 250ml of lorazepam had been received; we did not see any evidence that this medicine had also been delivered in liquid form and therefore staff spoken with said that this must have been a recording error. This demonstrates that people were at risk of ineffective medicine management practices resulting in the potential for harm. We also found that due to changes in staffing and the inconsistencies with the medicine and ordering processes, some peoples medicines that had been prescribed on an 'as required basis', such as pain relief had not been re-ordered and were therefore unavailable. Staff we spoke with confirmed that this meant if a person complained of pain, they would not be able to administer any pain relief. This meant some people may have experienced a delay in receiving pain relief due to ineffective medicine management practices within the home.

All of the evidence presented above demonstrated that the registered provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they were failing to do all that was reasonably practical to mitigate risks to people's health and safety.
Nevertheless, people we spoke with told us they received their medicines when they needed them and we saw that medicines were administered to people safely and where possible, with consent. We found that protocols were in place for medicines that were prescribed on an as required basis and staff we spoke with also knew how and when to administer these medicines when people were unable to ask for them independently. Staff told us that they had received training in the safe handling of medicines. Medicines were stored securely in a locked trolley or cabinet which were secured to the wall.

At our last inspection we found that insufficient staffing levels meant people did not always have the opportunity to enjoy activities outside of the home and/or were not always supported by two members of as stipulated within their risk management plans. During this inspection, we found improvements had been made in this area. Increased staffing levels meant that people had the opportunity to go out more often and they were supported by enough staff in order to keep themselves, staff and the wider community safe. However, the staff deployed did not always have the relevant knowledge, skills or experience to care for people with learning disabilities, autism, and/or mental health and any associated risks.

People we spoke with told us that they felt safe living at the home. One person said, "Yes, I am safe". Staff we spoke with were able to tell us how they would support someone in the event of a medical emergency such as a fall, head injury or choking.

We found that since our last inspection the provider had increased their staffing levels in accordance with the conditions we imposed on their registration at this location to promote the safety of the service in

December 2017. However, they had also recently undertaken a full staff reform process which meant that all existing staff members' (at that time) jobs were placed 'at risk' and staff were required to re-apply for their permanent positions. The manager told us that out of all of the staff that had re-applied and re-interviewed for their positions, only two of these were successful, both of whom were night staff. Other staff members were transferred on to the provider's temporary bank contracts; however, all but one declined this transfer and terminated their employment with the provider. This meant that the provider was reliant on agency staff to meet the increased staffing levels. A health care professional we spoke with who specialises in the care of people with learning disabilities, autism and mental health and who regularly visited the service to monitor and review a number of the people who lived at the home, told us that they were 'shocked' that the provider had taken this action. They explained that the lack of consistency in staff could have a detrimental effect on the people living at the home. Leading research including best practice guidelines also shows that people with autism and/or other moderate to severe learning disabilities have difficulty adjusting to changes in routines. Therefore people with these conditions can find inconsistencies or significant changes in care staff stressful and may lead to an increase in challenging behaviours, such as physical aggression and self-injurious behaviours. This meant that the provider had not always acted within the best interests of people living at the home, nor had they planned for the mitigation of any associated risks relating to this decision. For example, we found that one person was known to have a risk history of self-harm and suicide. Records we looked at stated that Conditions or circumstances that had been identified under which these risks were likely to occur, included 'anxiety' and 'a change of routine'. This document was originally dated 29 August 2016 and had not been consistently reviewed. It had not been reviewed since December 2017 therefore had not been reviewed since the significant staff changes. Prior to this it had not been reviewed between October 2016 and June 2017, nor between June 2017 and October 2017 (again, during a time of staff changes within the service). We saw a total of three difference records relating to this persons self-harm and suicidal ideology; all of which referred to different methods of self-harm or suicidal intent and therefore this person was considered to be at generalised risk of causing harm to themselves or taking their own life. Not one single document had captured this risk in its entirety and therefore staff did not have access to a full profile of this person's risk history and/or management plans. Not all of the staff we spoke with were aware of this persons extensive risk history or the nature of their potential risk behaviours in this area.

The provider had recruitment procedures in place for both permanent and agency members of staff. However, the provider had failed to ensure that only staff that were trained and checked for their suitability to work with people were deployed to work within the service. For example, the manager told us that due to the recent staff reform they were heavily reliant on agency staff. They showed us agency staff profiles which detailed the recruitment checks that the agency had performed. These checks included verification of their identity, references and the disclosure and barring service (DBS) checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. However, it failed to consider what skills and experience staff had in supporting people with learning disabilities, autism and mental health conditions alongside any associated risks such as self-harm and/or challenging behaviour.

This demonstrated that the registered provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they had failed to ensure sufficient numbers of suitably qualified, skilled and experienced staff were deployed in order to meet the specialist needs of people living at the home. This had the potential to impact on the safety of people and staff.

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2017, we found that people were not always cared for in the least restrictive ways possible. At this inspection, we found that sufficient improvements in this area had not been made. 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. For example, we continued to find that people had restricted access to their personal belongings. Staff we spoke with told us that one person was at risk of ingesting or drinking substances that may be harmful to their health, such as toiletries. For this reason, their wardrobe was locked. However, this meant that this person was also restricted access to their clothing which restricted their independence and autonomy within the home. We saw that this person had to ask staff if they could have a jumper because they were cold. Staff gave them the keys to access their wardrobe, similarly to our observation in November 2017. It remained unclear as to why, if this person was able to have access to the keys unsupervised, were they not allowed to have access to the wardrobe at all times. Staff we spoke with told us that there was no reason why they could not have access to their clothes and advised that the manager had spoken about people having lockable vanity cupboards to secure toiletries and to then allow access to their other personal belongings. We asked the manager about this and they confirmed that lockable cabinets had been ordered for this reason. The provider later told us that this person was known to destroy their personal belongings which formed part of the justification for this decision; however, the staff, manager or records we looked at did not corroborate this and there was no evidence of a best interests meeting concerning this restrictive decision. The provider acknowledged that improvements continued to be required in this area.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Information we hold showed that notifications had been submitted to us to advise that all of the people living at the home were subject to a DoLS authorisation. The manager confirmed this. We asked them whether anyone living at the home had any conditions applied to their authorisations. Conditions are requirements that are imposed within the authorisations to ensure people receive the care and support they require in order to meet the recommendations made by the DoLS' assessor at the time of the authorisation. Initially, the manager was unaware of what we meant by 'conditions' and once we explained, they told us that they were unaware of any conditions and would have to look at the authorisation paperwork; however this could not be found at the time of the inspection. We asked for this information to be sent to us at the time of our inspection, again via email on 5 April 2018 and again on our return visit on 12 April 2018. We have still not received this information at the time of writing this report. We asked the provider about this on the 12 April 2018 and they too were unaware of the details of people's DoLS authorisations. We also asked the provider for information regarding who people's Relevant Persons' Representatives (RPR's) were. An RPR is a person, independent of the care home, appointed to maintain contact with the person and to represent and support the person in all matters

relating to the deprivation liberty safeguards procedures. The provider was unaware of these details. This meant that people may not have been receiving the necessary contact and support from their RPR's as required with the conditions and requirements of the MCA and DoLS processes and procedures.

Furthermore we were told that one service user lacked the capacity to make decisions about where they lived and this was why a DoLS authorisation had been applied for and granted. However, we later found a tenancy agreement for this person, which was signed by them. Whilst this meant the provider was working outside of the conditions of their registration (because they are not registered to provide care in this way), it also meant that there was a contradiction of the application of the MCA and DoLS processes. This further demonstrated a lack of understanding concerning the MCA and DoLS on the provider's behalf.

Not all of the staff we spoke with were aware of people who had a DoLS authorisation in place or what this meant in relation to how they supported people on a day to day basis. Not all of the staff we spoken with had received training in this area and the manager was unable to provide training records of staff to inform this judgement. They told us that due to the high turn-over of staff and the reliance on agency staff, they had not maintained any records in relation to staff training or competency. The manager also confirmed that they had not received any information from the agency to show the training competencies of the agency staff deployed to work at the service, in relation to MCA, DoLS and any other area of practice.

Collectively, this demonstrated a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered day to day choices regarding their preferences for things such as what they wanted to eat, drink or do throughout the day. However, this was not always in accordance with people's specific care needs. For example, we looked at one person's care file and found that due to their autism they required a structured and planned routine. However, we saw staff sporadically offering this person various choices of activities including going out shopping, to the cinema, swimming, or for a walk, in a short space of time and in an ad-hoc, unstructured and seemingly chaotic manner. A health professional we spoke with told us that they had recommended that an activity planner be created with this person every morning which planned the daily activities in a very structured manner in order to promote the persons health and well-being. Without this level of structure and routine, the person can become anxious which may lead to behaviours that challenged staff.

One member of staff we spoke with who knew this person well told us that they tried to do a daily planner with this person every morning. However, due to the high turn-over of staff and the lack of experience and understanding that some of these staff members had about people's needs specifically, but also about caring for people with learning disabilities, autism or mental health conditions generally, this was not always applied in practice.

We asked the manager about what training the staff had received and asked to see the staffs training records and recruitment profiles. The manager told us that because of the staff reform, they did not have a training matrix to reflect the skills and competencies of the staff deployed to work at the service. The manager also told us that they had not received any information from the agency concerning the agency staffs' training compliance which led them to believe they had not received any training. For this reason, the provider had started to implement a new training programme for all staff, including agency staff. We asked the manager how they were assured that the staff deployed to work at the service had the relevant knowledge and skills they required to care for people safety and effectively. Their reply was, "Unfortunately, we did not". We looked at staff profiles, including those of three agency members of staff to see what information the provider held about these staff members and what experience the staff had in caring for

people with learning disabilities, autism and/or mental health conditions. We saw that one member of staff had experience of working with elderly people between 2014 and 2016 but their profile did not detail any information to evidence that they had any experience of working with people with learning disabilities, autism or mental health conditions. Two other staff profiles we looked at also indicated that both staff members' lacked experience in working in the care sector and they had unrelated qualifications. This meant the provider had deployed staff to work at the service without prior knowledge or assurance that they had the required training, skills, experience and competence to meet the needs of the service users living at this location, specifically but not limited to, mental health, learning disabilities and/or autistic spectrum disorders and any associated risk behaviours such as self-harm, suicide and or behaviours that challenge.

Despite us sharing our concerns with the manager and the provider at the time of our first inspection site visit on 28 March 2018 we found that no further action had been taken in relation to the training and competency of staff in these specialist areas. When we returned on 12 April 2018, we were told of an incident that had occurred within the home on 11 April 2018 involving a staff member whereby a person who is known to present with violence and aggression, had punched them. We were told that this incident had occurred because the staff member had 'challenged' the person about taking food from another person. A more experienced staff member advised that this could have potentially been avoided if the injured staff member had had training or experience in supporting people with autism and associated risk behaviours. This meant the provider had failed to promote the safety of people and staff by failing to ensure that staff deployed to work at the service were skilled and experienced in caring for people with specialist care and support needs.

This further demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they had failed to ensure sufficient numbers of suitably qualified, skilled and experienced staff were deployed in order to meet the specialist needs of people living at the home. This had the potential to impact on the safety of people and staff.

At our last inspection, the previous manager and the provider told us that they planned to spend more time in the communal areas, leading by example, whilst also facilitating observed practices, spot checks and staff supervisions. Supervision is typically a one to one meeting between a manager (or a senior) and a staff member. Its purpose is to provide a safe, supportive opportunity for staff to engage in critical reflection in order to raise issues, explore problems, and discover new ways of handling situations or issues within the workplace. It is also an opportunity to discuss learning and development opportunities and for managers to oversee staffs work practices. However, staff we spoke with told us that this had not happened. The manager told us that due to the staff reform, they had not facilitated any staff supervisions, staff meetings or competency observation checks because the service predominantly ran on agency staff. The manager recognised that it may have been useful to have facilitated some staff supervisions and observations to monitor the competency of agency staff to inform whether or not they wished for those agency staff members to be re-deployed to the service in future. The manager also told us they were hopeful that some of the agency staff would apply for permanent positions and again recognised that the lack of staff monitoring and observations was a missed opportunity to inform their recruitment practices.

We found that people living at the home had access to doctors and other health and social care professionals. People and visiting professionals we spoke with and records we looked at showed that people were supported to maintain contact with external agencies involved in monitoring and supporting their health and well-being, including specialist learning disability and mental health services. However, communication systems both within the service and with external agencies were not always effective to ensure people received the care and support they required. Visiting health professionals we spoke with told us that they found the significant levels of staff changes and the lack of specialist experience and knowledge

of staff within the service 'frustrating'. They explained that information and recommendations they made were rarely implemented and they felt this was due to a lack of communication and consistency within the service. For example, one visiting professional explained that they had spoken with a member of staff at length about ways they could support and work with one of the people living at the home. However, when they returned to review the progress, they found that the staff member they had spoken with previously had left and the good practice had not been shared or sustained. Another visiting professional provided an example of a detailed recommendation report that they had provided to assist staff with understanding the care and support needs of one of the people living at the service. However, they stated that our feedback from observations we had made during our inspection was a 'prime example' of who their expert knowledge, experience and advice is not implemented within practice.

Staff we spoke with had some understanding and awareness of the Equality Act and what this meant in practice. For example, we were told that one person was a Muslim and therefore was 'not allowed' beer and other specialist dietary requirements were catered for. We also found that people were supported to engage in activities related to their faith and religion. One person we spoke with told us that they were going to the Mosque and asked us if we would like to join them. Furthermore, we found that the provider explored and supported people to express their sexuality and any associated needs by way of planning this as a part of their care and liaising with other agencies, as required. One member of staff we spoke with said, "We recognise that sex is a big part of adult life and can still be important to people with learning disabilities, so we support them with any issues within this area as much as we can". People were also supported to access other support agencies that could enable them to access community services and activities of interest without discrimination. This included seeking voluntary work or attending college courses, day centres or planned activity groups.

We saw people were given choices about what they had to eat and drink. There was a flexible approach to mealtimes within the service and some people were supported to prepare their own meals, whilst staff prepared meals for others'. Staff told us that they encouraged people to be as independent as possible within the kitchen and staff supervised this to promote people's safety. On our first day of inspection, we saw some people enjoyed a take away with staff, whilst others enjoyed the food that staff prepared for them. One person we spoke with said, "It's [food] good, they [staff] are good cooks". Records we looked at showed that peoples nutritional needs had been assessed and referrals had been made to the relevant professionals where required.

Inadequate

Is the service caring?

Our findings

The providers systems, processes and oversight of the home were not sufficient or effective and did not ensure that people received care that was safe, effective, responsive and well led, which meant that people were not cared for. Whilst some individual staff members were reported and observed to be caring and kind, we found that some aspects of the care being provided to people was not always caring. For example, due to the lack of staffs specialist skills, competencies and experience, people did not always receive the care and support they required in the way they required it in order to promote their safety and well-being. Staff had not always identified when people were at risk of abuse and/or avoidable harm and had failed to advocate on behalf of people in order to promote their safety, dignity and comfort. For example, one of the staff members we spoken with told us that they believed the environment 'could be better' and provided the lack of curtains in people's bedrooms as an example. However, they had not reported this or recorded it in the maintenance book.

The environmental and maintenance issues identified during the inspection demonstrated that the provider had failed to learn lessons from our previous inspection and had continued to compromise people's safety, dignity and comfort, placing people at risk of physical and psychological harm. We were appalled to find people continued to live without adequate window dressings, especially within their en-suite facilities. This significantly compromised their privacy and dignity because the large window was unfrosted and overlooked by passers-by on the public street and a local park. Despite us raising this as a significant concern on 28 March 2018, we found that these issues had still not been addressed when we returned on 12 April 2018. Another example we saw was one person who had a plastic matrass (usually installed to promote infection prevention and control practices in relation to continence needs) with an ill-fitting bottom sheet, making him susceptible to lie on cold plastic or to sweat. Staff we spoke with or records we looked at did not indicate that this person required a specialist matrass in relation to any continence needs and it was unclear why this was in situ, or why staff had not ensured suitable bedding had been maintained. Further to this we saw another person who had a fabric matrass that was considerably soiled on both sides and required replacing. Staff we spoke with told us that this person sweated a lot which meant the matrass was often soaked through and caused stains. We asked the provider what assessments they carried out to determine what mattresses people required and how they ensured these were suitably maintained. They were unable to explain to us why one person without any specialist continence or care needs had a specialist mattress, whilst another person who would have benefited from this, did not. They assured us that this person's mattress would be changed as a matter of priority.

Throughout our inspection, we saw people appeared comfortable and relaxed in the presence of staff. However, it was difficult to ascertain the consistency in this presentation from one day to the next due to the inconsistency in the staffing team. For example, on our first day of inspection we saw that there was a vibrant atmosphere within the home which at times bordered chaotic. On our second day of inspection it was much calmer. This showed the impact that different staff can have within a service and on the experience of people they care for. It also reflected the lack of knowledge and experience some staff members had in caring for people with learning disabilities and those diagnosed with an Autistic Spectrum Disorder. It was also difficult for us to ascertain the impact of the different staffing teams had had on people

due to the inconsistencies in the record keeping within the service.

Nevertheless, people we spoke with told us they were happy living at Moseley Gardens. One person said, "I like it here, yes". Another person nodded to indicate 'yes' when we asked if they liked living at the home and if they liked the staff. Professionals we spoke with told us that they had no issues with the staff that supported people and felt that staff did their best within the constraints of the provider.

Requires Improvement

Is the service responsive?

Our findings

We found that people's care records contained detailed information about their care and support needs. However, these had not always been reviewed consistently or organised in a way that ensured staff had access to the most recent, relevant and comprehensive information pertaining people's care needs and any associated risks. Nevertheless, staff we spoke with told us that they were given time to read people's care files and despite having limited experience of working at the service, were able to give us a generalised overview of peoples likes, dislikes, support needs as well as some associated risk factors. Staff we spoke with told us they enhanced their knowledge and got to know people gradually by talking to them or by observing their likes and dislikes.

Records we looked at showed that some people had signed their care plans to demonstrate that they had had some involvement in the planning or review of their care. We were told that new communication aids had been introduced to support staff interactions with people since our last inspection. Some of the staff we spoke with told us that these were available and identified people who would benefit from them. However, we did not see any members of staff use these communication aids throughout our visits to the service.

People we spoke with told us that they were consulted about some of the changes that had taken place within the home, such as changes to the environment. For example, one person confirmed that staff had spoken with them about painting their room and putting up pictures of interest on the walls. People, staff and records we looked at also showed that the provider had recently held a meeting with people to discuss changes to the staffing team. The manager explained that further meeting were scheduled to ensure this level of 'service-user' involvement was maintained.

We saw that pPeople were supported to engage in activities that were meaningful to them, such as going to day centres, colleges going for walks, to the local shops or visiting the airport. We saw people playing darts together and with staff. This was an improvement since our last visit and we were told that this was the direct result of increased staffing levels. One member of staff said, "After your [CQC] last visit, the one thing that has changed considerably for the better is the staffing levels; we [staff] are now able to support people and do more things with people both in and outside of the home; and more importantly, do this safely". However, we found that improvements were required to the structuring and organisation of daily activities to ensure that people are engaged in activities of interest and are supported to maintain a purposeful routine tailored to their individual needs, interests and preferences. Quality standards set for the care of people with learning disabilities states that by ensuring people have planned, personalised daily activities will help to reduce rates of behaviours that challenges. This would also further enhance quality of life and well-being.

We found that people were supported to maintain relationships with people that were important to them. One person told us that their family often visited them at the home and they also enjoyed going out with their family. We also heard about how the provider supported people to develop their independent living and social skills. For example, one person told us that they were looking forward and working towards having their own flat and finding a girlfriend.

People we spoke with told us that they would speak to staff or the manager if they had any complaints to raise. One person said, "If not happy I would speak [staff member's name]". We asked the manager whether they had received any complaints since our last visit and asked for any records they may have concerning complaints. The manager told us they were not aware of any complaints and they did not have any records of this nature to show us. They advised that a new record keeping system is due to be implemented in April 2018 and that this will include a new complaints recording process.

Inadequate

Is the service well-led?

Our findings

At a previous inspection in January 2016 we found that the provider had not ensured that the systems and processes in place to monitor the safety and quality of the service had been operated effectively. We therefore found evidence to support a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we returned in January 2017, we found that whilst some improvements had been made, further improvements were required. We continued to find shortfalls in the provider's quality monitoring systems at our last inspection in November 2017 and the provider was rated as 'Inadequate' in this key question. At this inspection, we found that progress had still not been made or sustained in these areas further deterioration was noted, which continued to impact on the safety and quality of the service provided to people. This meant that the provider had a history of requiring improvement in these areas and has demonstrated that they cannot always make or sustain the required improvements, leading to a repeated breach of regulation 17. You can see what action we have taken at the end of this report.

We continued to find evidence that showed the provider's quality monitoring processes were ineffective. The provider had failed to ensure that effective record keeping systems and governance systems were in place. This meant that staff did not always have all of the information they needed concerning people's risk histories and support needs in order to safeguard people, staff, and visitors against the risk of actual or potential avoidable harm. For example, one persons fragmented risk assessments and care support plans had failed to provide a complete overview of their generalised risks associated with self-harm and suicidal ideation.

Further to this, the provider had failed to ensure that staff deployed at the service had the relevant knowledge, skills and experience to care for people with learning disabilities, autism and/or mental health conditions, including but not limited to the associated risks such as self-harm, suicide or behaviours that challenge. For example, we were told about an incident that had occurred within the home whereby a member of staff had been physically assaulted by one of the people that lived there. This was because of the way they had managed a situation and spoken to a person, contrary to the needs of a person with living with autism.

The provider had not facilitated any audits or other quality monitoring practices to continuously monitor, assess, identify and mitigate risks associated with the environment, including but not limited to infection control or maintenance. This led to on-going maintenance and safety issues within the service which included ligature risks and issues that compromised people's privacy, dignity and comfort.

Oversight of care records including daily observations and behaviour charts had not been facilitated and therefore the provider had failed to recognise that these lacked detail, meaning or sufficient analysis. Accidents or incidents that occurred within the home had gone unrecorded and unreported as required by law.

The provider had also failed to act and respond to many of the shortfalls that we had identified on our first

inspection visit on 28 March 2018, in a timely manner, meaning people remained at risk, despite the manager and provider being aware of the seriousness of our concerns. For example, when we returned on 12 April 2018 we continued to find fragmented risk assessments and care files, ligature risks, lack of window dressings, faulty windows, and infection control risks.

The provider had also failed to maintain oversight of other significant safety aspects of the service including medicine management and the monitoring of fire safety practices within the home. The manager told us that new quality monitoring systems and processes were being developed and were due to be implemented in April 2018. However, they recognised that more should have been done since our last inspection in November 2017 to demonstrate that improvements were being made to promote the safety of the service, in a much timelier manner.

The service was required to have a registered manager in post as part of the provider's conditions of registration. 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. There had not been a registered manager in post since August 2017. Prior to this, the service had also had two other registered managers spanning back to 2015. At the time of our last inspection, the provider had appointed a new manager who had been managing the day to day running of the service since October 2017 and they had applied for their registration with us. However, they withdrew their application to register with us in January 2018 and their employment with the provider was terminated. Since this time, the provider had recruited another manager who was deployed to manage the service in February 2018. We found that whilst this manager was approachable and co-operative throughout the inspection and demonstrated a motivation and determination to succeed within the role and make improvements, they lacked experience within this area of practice. The manager told us that their experience was in general practice and that this would be their first position in managing a residential service. They did not have any experience in working with people with learning disabilities, Autism or mental health conditions. A health care professional we spoke with told us that they were 'shocked' to find out that the provider had recruited a person to manage a 'specialist service' such as this, without any prior knowledge or experience within this area. They also told us that this made it particularly difficult to talk to them about people's specialist needs, including risk behaviours. We also found that the manger's lack of experience in residential care also meant they lacked understanding or awareness of some of the requirements of this role, such as the need for internal medicine management audits, the need to monitor, record and report incidents that occurred within the service, or the need to be aware of and meet conditions laid out in peoples Deprivation of Liberty Safeguards (DoLS) authorisations. More of a concern we found was that the provider also lacked any skill or experience in the health and social care industry, which meant they were reliant on the knowledge, skill and experience of the managers that they deployed. We discussed this with the provider at the time of our inspection. They told us that they had deployed a consultancy agent to support them in making the required improvements and to meet the requirements of their registration. They advised us that the consultant deployed had a wealth of experience in the social care sector and was hopeful that they would be able to support them in achieving the actions required.

The registration history for this location showed that there had been an inconsistent leadership structure within the service which had had a negative impact upon the quality and safety of the service. This also meant the provider was not meeting the conditions of their registration and was committing an offence under section 33 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering what action to take in relation to this offence.

Staff spoken with were not always aware of who the manager of the service was. Many of the staff we asked

identified the shift leader as a person they would go to in the event of an emergency, incident or if they needed to consult a member of the management team. We found that the shift leader was in fact a care assistant who had been transferred over to the provider's 'bank contracts' but was the only member of staff deployed consistently each day who had experience of working at the service. We were told that the manager rarely worked a full day as they were always busy tending to business at head office and the senior carer arrived each day at mid-day. When we arrived at the service on 28 March 2018, the manager was not on site and arrived approximately 30 minutes later when contacted by the shift leader. When we contacted the service on 09 April 2018, again we were told that the manager was not on site. When we arrived at the service on 12 April 2018, again no management staff were available until the provider arrived at approximately 11:35. Throughout all of these absences, the shift leader supported the inspection process and staff continued to recognise them as the consistent member of the management team, despite this not being a part of their roles and responsibilities as a care assistant.

All of the above shows that the provider had continuously failed to sustain or make sufficient improvements since our previous inspections and the quality and safety of the service had deteriorated further. This means that the provider remains inadequate overall and remains in special measures. At our last inspection we served a notice of proposal to cancel the provider's registration at this location. We have received representations against this action from the provider which are currently under review. However, as a direct result of the failings identified at this inspection, we have taken further urgent enforcement action to impose conditions on to their registration for this location which requires them to take immediate action to rectify the seriousness of the failings we have found. We have also asked for an action plan that details what action the provider plans to take and by when, to ensure the required improvements are made.

We will continue to monitor the safety of the service and where necessary, another inspection will be conducted within a further six months. If there is not enough improvement, so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we re-inspect it and it is no longer rated as Inadequate for any of the five key questions it will no longer be in special measures.