Scope

The Hollies

Inspection report

1-3 The Hollies
Halton Brook Avenue
Runcorn
Cheshire
WA7 2FU

Tel: 01928567553
Website: www.scope.org.uk

Date of inspection visit:
21 September 2016
23 September 2016
05 October 2016
19 October 2016

Date of publication:
15 December 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 21 and 23 September and the 5 and 19 October 2016 and was unannounced.

1– 3 The Hollies is a purpose built care home comprising of three separate bungalows providing personal care and accommodation for up to nine people who have a physical disability. Each bungalow has three bedrooms, separate lounge, kitchen dining room and bathroom and toilet. The premises are equipped and adapted to meet the needs of the people who live at the home. There is level access to each property and tracked ceiling hoists have been installed where required. Each bungalow has its own garden area and off road parking is available for several vehicles. Staff and the people who use the service have the use of a small office which is located adjacent to bungalow 3.

The home is located in a residential area of Runcorn and is within easy access of the local amenities. There were nine people living in the home.

When we carried out our last comprehensive inspection of the home in October and November 2015 the registered persons were found not to be meeting all the requirements for a service of this type. We identified breaches of the relevant regulations in respect of the need for consent, safe care and treatment, nutrition, good governance, and staffing and an overall rating of Requires Improvement was awarded. We carried out a further focused inspection of the home on 19 February 2016, and found further breaches of the relevant regulations in respect of the need for safe care and treatment, good governance, and staffing and an overall rating of Inadequate was awarded.

Because the overall rating for this service was 'Inadequate' the service was placed in 'Special measures' following our last inspection. The provider undertook a service review and subsequently developed extensive action and recovery plans designed to bring about the required improvements in the provisioning and delivery of safe and effective care. The management team including a team leader, registered manager and area manager was replaced with interim managers and in August 2016 a new team leader, manager and area manager were appointed. This inspection was carried out to check if the required improvements had been made.

At the time of our inspection the new manager was in the process of applying for registration as "registered manager "of the services. A registered manager is a person who has registered with the 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.

Before our inspection we received feedback from the local authority contract monitoring team. They told us that, whilst they did not have a contract with SCOPE they had a duty to the people who lived at the home to

ensure they received safe and effective care. The home had been subject to an improvement plan since November 2015 and there was on-going monitoring by the contracts monitoring team. Significant improvements had been identified and whilst there was still more to be achieved managers and staff were said to be working collaboratively with the contracts and monitoring team and other health and social care professionals to ensure that the people who lived at the home received safe and effective care.

Prior to this inspection we met with the provider's representatives including a senior manager and the nominated individual. They told us that their internal enquiries had found that the home had been poorly managed for a number of years. The consequences of ineffective management had resulted in poor outcomes for the people who lived at the home and a disempowered staff team who had lacked the required confidence and skills to carry out their duties and responsibilities effectively. To address these longstanding failings the provider's recovery plan was designed to bring about the required improvements in care practice and to ensure that staff received the guidance, training, support and leadership they required to conduct the service in accordance with the provider's values and beliefs. Senior managers told us that whilst much had been achieved since February 2016 they were aware that there was still room for improvement.

The people who lived at the home told us that things had improved. They said they were happier because there were more staff which meant there were more opportunities to get out of the house and take part in ordinary activities such as shopping, going to the cinema and local cafés.

We found that the atmosphere in each of the three bungalows had much improved and at times was positively vibrant with fun and people engaged in a range of activities, or coming and going from activities in the community. There were times when the atmosphere was more relaxed reflecting the moods and temperament of the people who lived there but was always welcoming and sociable. We saw staff reinforcing people's rights, involving them in decision making and empowering them in all aspects of daily living.

We found that the provider had made significant improvements in the management of the home and the delivery of care. We could see from their quality assurances processes that they were continually striving to improve the service and provide safe and effective care and support for the people who lived at the home. However, it was clear that there was still much work to be done to ensure people received safe and effective care and support. We identified further breaches of the relevant regulations in respect of safe care and treatment, eating and drinking, good governance, staffing training and development, person centred care, safeguarding vulnerable people from abuse and consent to care.

The overall rating for this service remains as 'Inadequate' and the service will therefore remain 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 is made within this timeframe so that there is still 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 if they do not improve. 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 safe.

People told us that they felt safe. However the health and well-being of some of the people who lived at the home was at risk because the registered provider was failing to provide care in accordance with their needs.

Managers and staff were not doing all that was reasonably practicable to identify, control and mitigate risks and ensure that people were protected from unsafe and ineffective care.

Medicines were not always managed safely or effectively.

There were times when people did not get their medicines as their doctors had prescribed it.

There were times when some staff did not have adequate experience, training or support to meet people's needs in a safe and effective way.

There were sufficient numbers of staff on duty to ensure people were supported to live fulfilling lifestyles.

Recruitment records demonstrated there were systems in place to help ensure staff employed at the home, were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People told us that they were well cared and the staff team presented as caring and committed to the provision of person centred and compassionate care. However, there were gaps in staff's knowledge and skills which had put the people who lived at the home at risk of their needs not being met.

Staff had not always received such support and training and professional development as is necessary to enable them to carry out the duties they were employed to perform.

Managers and staff were acting in accordance with the Mental Capacity Act 2005 to ensure that people were receiving the right level of support with their decision making.

Is the service caring?

Good

The service was good.

Managers and staff were seen to be kind and compassionate in their interactions with the people who lived at the home.

People were treated with respect and the staff understood how to provide care in a dignified manner. They respected each person's right to privacy and promoted their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us and we could see from their records that they were involved in planning their care and support but we found that staff were not responding effectively when people's needs changed. Care plans were not routinely updated and evaluated and people's needs were not always met as a consequence.

The registered provider had an established complaints procedures but complaints were not always investigated effectively or acted upon.

Staffing levels had improved so the people who lived at the home were happier because there were more opportunities to get out of the house and take part in ordinary activities such as shopping, going to the cinema and local cafés in the local community.

Is the service well-led?

Inadequate

The home was not well-led.

Systems and processes established to ensure compliance with the regulations were not used consistently or effectively to identify and solve problems and ensure the welfare of the people who lived at the home.

The Hollies

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 23 September and 5 and 19 October 2016 and was unannounced. The inspection was carried out by an adult social care inspector and a pharmacist inspector.

We reviewed the information the Care Quality Commission already held about the home. We contacted the local clinical commissioning group Care Home pharmacist and Medicines Management and the local authority safeguarding, contracts monitoring, learning disability teams before and after the inspection and they shared their current knowledge about the home.

During the inspection we spoke with all eight of the people who lived at the home. We talked with 17 members of staff including nine support workers, an agency support worker, a senior support worker, two team leaders, the designated manager, recently appointed administrator, area manager and quality assurance manager. We also spoke with a visiting relative. We looked at three care and support plans as well as other records and audit documents. We looked around the building including, with the permission of people who used the service, some bedrooms.

Inadequate

Is the service safe?

Our findings

The atmosphere in each of the three bungalows was relaxed, warm, welcoming and sociable throughout the inspection. People who lived at the home told us that they felt safe and we could see that they had good relationships with the staff who supported and cared for them. One person who told us that they were concerned about the home's future said "I am happy and well cared for". They said "life is better now, much better, there are enough staff so I get out more and can make plans, I'm going to Star Trek convention for my birthday". They told us that they liked all the staff and named them. Another person told us that "things had improved and that everything was OK". Other people told us how things had improved. They told that there were always enough staff on duty so they were able to go out and take part in activities in the community. One person was unable to express their views verbally but in answer to our questions they gave the thumbs up along with a big smile. Another person had an "I-pad" which they used with great skill to express their views. They told us that the home was good, they were happy and the food was good. A visiting relative said staffing had improved significantly since our last inspection so much so that people's quality of life had improved. They explained that having enough staff to support people to get out and about was vital and they hoped that these improvements would continue.

At our last inspection in February 2016 we found that there was an insufficient number of suitably, experienced qualified and competent staff to ensure the well-being of the people who lived at the home. Managers and staff were not responding effectively when people were found to be at risk from hazards presented to them by their condition or the environment in which they lived. We took enforcement action in line with our enforcement procedures and put the service in special measures.

In response to our findings the provider (SCOPE) took action to address fundamental inadequacies in the management and conduct of the home that had been identified by the Commission, the local authority contracts monitoring team, community based health and social care professionals and their own internal quality assurances processes. An action plan known as a recovery plan was designed and implemented to bring about the required improvements in care practice and to ensure that staff received the guidance, training, support and leadership they required to conduct the service in accordance with the provider's values and beliefs. The management team including a team leader, registered manager and area manager was replaced with interim managers and in August a new team leader, manager and area manager was appointed.

During this inspection we could see that deficiencies in service provision were being addressed by degree and we identified examples where effective action had been taken to ensure people remained safe. The management structure had been greatly improved with the addition of two senior support worker posts and the provision of an additional team leader on a temporary basis, to support the manager with the implementation of the recovery plan. Staffing levels had significantly improved and care plans and risk assessments had been re-written and revised to help ensure care was provided in accordance with people's needs and that risk was mitigated. We could see that the actions taken by the provider and the new management team to ensure the safety and wellbeing of people who used the service were having desired outcomes in some aspects of care. However, we also identified serious failings in assessment, care planning,

monitoring, evaluation and review which had put some people's health, safety and wellbeing at risk.

A person who had been in hospital for an operation which significantly changed their needs was readmitted to the home in an unsafe way. We found that staff did not have the required knowledge, skills and experience to meet their needs. There was evidence of confusion about their medicine which resulted in this person not getting vital medication in accordance with their doctor's prescription. There had been no re-assessment of their needs and no evidence of any effective care planning or risk assessment or in order to identify and mitigate risks associated with their changed needs. Failure to assess this person's needs and failure to identify and mitigate risks jeopardised their wellbeing and put them at risk of ineffective and inappropriate care and support.

We found that several people living at the home had been assessed as at risk of developing pressure ulcers. Pressure relieving equipment including specialist air flow mattresses had been provided for them. However, we noted that their risk assessment and care plans did not provide staff with guidance as to how this equipment should be used. When we checked the specialist air flow mattresses for five people assessed as requiring them we found that all were set at an incorrect weight with one set incorrectly by as much as 54kg and another by as much as 41Kg. Failure to use this equipment in accordance with the advice of care professionals and the manufactures instructions put these five people at increased risk of developing pressure ulcers.

Records showed that a person who lived at the home who was at risk of malnutrition was not eating enough calories to sustain their health and well-being. Records showed that a dietician had been consulted as to how this person's calorific intake might be improved in July 2016. However when their care plan was re written in August 2016 there was no mention of the dieticians advice and guidance. We observed that staff were not following this guidance and when we spoke to them about it they confirmed that they had not been made aware of it. We could see that managers and staff were completing a Malnutrition Universal Screening Tool (MUST) but had not responded when this person's weight had dropped to a level which indicated they were underweight. MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers. Failure to assess this person's needs, effectively and failure to identify and mitigate risks jeopardised their well –being and put them at risk of ineffective and inappropriate care and support.

We observed staff were not following the eating and drinking guidelines for a person assessed at risk of choking. We observed them over two mealtimes and could see that whilst they provided this person with support and constant supervision they were not assisting the person to clean their teeth to remove any food debris after eating. When we asked the staff they told us that they did not know about this aspect of this person's care plan. We observed another member of staff preparing food for one person according to the written guidelines for another. When asked it was clear that the staff member was not aware as to the precise guidelines for each person. This lack of attention to personal requirements put both these people at risk of ineffective and inappropriate care.

Medication was only handled by carers who had been trained and competency assessments had been carried out. We found that medicines were stored securely and people were usually given their regular medicines correctly. Many people using the service were prescribed medicines such as creams, painkillers and laxatives that were to be used only when required. Carers did not always have enough information to ensure these medicines were given correctly and in a way that met the individual needs and preferences of each person. This meant that people did not always get the full benefit from their medicines. We saw two examples where people had not been given their laxatives appropriately and this had impacted on their

health and wellbeing. We saw another example where antibiotics had not been given with appropriate intervals between doses. Antibiotics must be given at regular intervals in order for them to be effective. The course of treatment had not been successful and a further course of antibiotics was needed in order to treat the infection. An audit system was in place, however this was not robust and we discussed ways in this this could be further developed.

All the issues above constitute further breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered persons were not doing all that is reasonably practicable to mitigate the risks to the health and welfare of the people who lived at the home or to ensure that medicines were managed safely.

We saw that the provider had a safeguarding policy in place. This was designed to ensure that any safeguarding concerns that arose were dealt with openly and people were protected from possible harm. The new manager was aware of the relevant process to follow and the requirement to report any concerns to the local authority and to the Care Quality Commission (CQC). Records showed that there had been a number of safeguarding alerts and care concerns reported to the local authority since January 2016. The area manager provided detailed records of each incident showing outcomes of the various investigations and details of any action taken, where necessary, to safeguarding people from abuse and inadequate care.

We spoke to the local authority's safeguarding practice manager and asked them whether they were satisfied with the home's safeguarding procedures and whether staff worked collaboratively with the local authority to protect vulnerable people from abuse. The safeguarding practice manager told us that they had met the new manager and found that they were proactive and worked in partnership in the interests of safeguarding vulnerable people.

We did see that one body map in a person's care file showed that staff had identified an unaccounted for injury. This incident occurred before the new manager started work at the home. There was no evidence that this injury had been assessed or accounted for and it had not been reported to the local authority in accordance with locally agreed safeguarding procedures.

Staff members confirmed that they had received training in protecting vulnerable adults and that this was updated on a regular basis. The staff members we spoke with told us that they understood the process to follow if a safeguarding incident occurred and they were aware of their responsibilities for caring for vulnerable adults. However, one member of staff who had received training on safeguarding adults was unaware as to which agency they would contact to report any abuse , suspicion or allegation of abuse should they believe it necessary circumvent SCOPE's internal reporting procedures. There was no mention that staff could report directly to the local safeguarding authority should they believe it necessary to do so on the poster which highlighted internal safeguarding procedures. The area manager gave assurances that this oversight would be corrected.

We looked at the files for two members of staff to check that effective recruitment procedures had been completed. We found that appropriate checks had been made to ensure that they were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held suitable proof of identity, the application form with full employment history and references as well as the job description.

Requires Improvement

Is the service effective?

Our findings

All people spoken with during the inspection told us or indicated that their needs were met.

The home was designed specially to meet their needs and promote their independence and we could see it suited them all. When we asked people whether they were settled and enjoyed living at the Hollies all were unanimous in their praise for the home. In fact two people told us that they loved it.

Some of the people had difficulty expressing their views verbally but were all good at communicating what their needs were, what they wanted or what they were unhappy with. As we had seen on previous inspections there were lots of smiles and spontaneous laugher. We could see that they had positive relationships with the staff and there was a sense of mutual respect and regard between both groups of people. It was clear to us that the people who lived at the Hollies regarded it as their home and they cherished it. Staff reinforced each person sense of ownership and belonging the way they supported people and empowered them to take the lead in all interactions with the inspector. There was light hearted banter when the inspector asked one of the people if he could use the toilet. They responded raucously with an emphatic "No" but then laughed out loud saying "course you can". Other people at the home found this exchange amusing and joined in the laughter too. Another person took the initiative, taking control of the inspection and provided a conducted tour introducing the inspector to the people who lived at the home and staff. In their own bungalow they asked the inspector whether they would like a cup of coffee and with the assistance of staff made one for him. It was clear that the people who lived at the Hollies knew their rights and knew that it is their home first and foremost. This made for a very sociable and relaxed atmosphere.

When we carried out our last comprehensive inspection of the home we found that the service was not consistently effective. There was no doubt that the staff team cared for people but there were gaps in their knowledge and skills which had put the people who lived at the home at risk of their needs not being met. In response to the concerns we raised the provider drew up and implemented a recovery plan which included several action points on the training and development of staff including direct supervision, observation of their practice and competency assessment.

There had been significant changes in the staff team since our last inspection with the introduction of new staff, re deployment of staff from another home in the vicinity which had closed as well as a small number of agency staff covering sickness. Most of the staff spoken with and observed were generally familiar with the needs of the people who lived at the home and had or were developing good relationships with them. Whilst there was no doubt that staff were skilled in the way they interacted with people and much has been learned by them in the preceding months we could see there were still gaps in their knowledge which had put people at risk of receiving ineffective or inappropriate care.

We identified two examples where staff had failed to act effectively when people had lost weight unintentionally. Their care plans and risk assessments lacked sufficient detail and although staff were monitoring their daily nutritional intake there was no analysis of their diet and no evaluation of their care

and support plans to determine whether their diet was satisfactory.

Records showed that one of the people who was underweight was not consuming sufficient food to maintain their weight and advice given by a dietician in July 2016 had not been implemented. Managers and staff spoken with had no knowledge of the dieticians' recommendations which had been overlooked when the persons "Person Centred Plan" had been revised and re-written in August 2016.

Some of the staff had received training on the Malnutrition Universal Screening Tool (MUST) but had failed to update this person's MUST assessment effectively when they continued to lose weight and their body mass index (BMI) indicated they were underweight. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings such as The Hollies and can be used by all care workers.

Failure to assess this person's needs, effectively and failure to identify and mitigate risks of malnutrition had jeopardised the wellbeing of both people and had put them at risk of ineffective and inappropriate care and support.

The above comprises a breach of Regulation 14(1) Meeting Nutritional and hydration needs, in that service users' nutritional needs were not always met in a way that would adequately sustain good health.

Previous inspections and safeguarding investigations had highlighted risks of people choking and aspirating food because staff did not have sufficient knowledge of each person's risk assessments and eating and drinking guidelines. These eating and drinking guidelines had been produced by the relevant person's speech and language therapists (SALT) and were tailored to their precise individual needs. It is imperative that these guidelines are adhered to in the interests of the health, safety and wellbeing of each respective person.

We could see that some staff had sufficient knowledge of each person's needs and prepared foods and supported them with their eating and drinking accordingly. However, we observed that staff had not followed one person's eating and drinking guidelines on two occasions in that they had not enabled the person to clean their teeth after their meal to remove food debris. When we asked the relevant staff members about this apparent omission they told us that they were not aware of the recommendation which was clearly stated on the person's eating and drinking guidelines.

We also observed a staff member prepare food for one person according to the eating and drinking guidelines for another person. When we asked this staff member for an explanation it was clear that they had confused the two and did not have a clear understanding of each person's individual requirements as detailed in their respective eating and drinking guidelines.

In an attempt to raise the awareness of each person's eating and drinking guidelines managers had told us that they had taken the precaution of posting them in the kitchens of the respective bungalows where the relevant person lived. On the first day of our inspection we found that one person's eating and drinking guidelines were not posted in the kitchen and when asked an agency staff member had no knowledge of them.

A person who had been in hospital for an operation which significantly changed their needs was readmitted to the home in an unsafe and unplanned way. We found that staff did not have the required knowledge, skills and experience to meet their needs. The person had had an operation and fitted with a medical device

to assist with their nutrition via a tube which entered through their stomach wall. Staff needed specialist training in the safe and effective operation of the device and to prevent infection of the site. Managers told us that 12 staff had received training on the use of the device and three of the 12 were on duty the weekend this person was re-admitted to the home. However when we looked into what training had been provided we found that there had been no practical element to the training, no assessment of competency subsequent to the training and managers had not ascertained whether the person who had provided the training was qualified to do so. We looked at the supervision records one of the staff who had been on duty in the home the weekend the person was re-admitted and found that this staff member had raised concerns about the adequacy of the training. Managers had not responded to this member of staff concerns. We found that this put this person at risk of receiving unsafe care.

The issues above constitute further breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered persons had not ensured that the persons providing care or treatment to service users have the knowledge, competence and skills to do so safely.

The team leader and other staff spoken with told us that they had a lot of training in the last few months on relevant topics including medication, moving and handling, dysphagia and challenging behaviour. However, the training matrix highlighted that were several gaps in staff training such as 13 of the 36 staff listed had not done fire training in the last year and a further 4 had not had fire training in the last two years. Ten of the 36 staff had not done moving and handling training in the last 2 years. Only three of the 36 staff were recorded as having done training on infection control. Only five of the 36 staff were recorded as having done training on Food hygiene, but none of these staff had done it in the last three years. Only 12 of the 36 staff were recorded as having done training on skin integrity and pressure area care including pressure area risk assessment even though most people living at the home were assessed at high risk of pressure area sores. Only eight of the 36 staff were recorded as having done training on dysphagia (swallowing problems) even though three of the people living at the home were assessed at high risk of choking on or aspirating food.

We were informed that 12 of the 36 staff listed on the training matrix were absent from work at the time of our inspection. However, managers acknowledged that taking these absences into account there were significant gaps in staff training at the home. We asked the manager as to whether training plans had been developed to address the gaps in staff training. We were told that training plans were being developed at the time of our inspection but managers were unable to make these available until after our inspection.

The issues above constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing in that staff have not always received such support and training and professional development as is necessary to enable them to carry out the duties they are employed to perform.

Staff told us that they were well supported and morale amongst their number was improving. However, records showed that staff had not always received supervision meetings in accordance with SCOPE's policies and procedures. We found an example where a staff member cited a lack of support and had requested supervision on the 14 April 2016 but this had not been given them before they resigned and left on the 25 May 2016. In another example a safeguarding investigation into allegations of poor treatment had concluded that "there does seem to have been a culture concern" but there was no record the staff member in question being offered or given supervision to address such issues. More recently we could see that a concerted effort was being made by the management team to ensure staff were provided with the supervision and support they needed. Records showed that most staff had received one supervision

meeting in the previous 12 months period. On the second day of the inspection we checked staff supervision records as to whether issues we had raised regarding staff practice on the first day had been addressed with them during supervision. We found that it had and we could see that staff were benefitting from on-going observation of their practice and what they described as constructive and helpful feedback. This was provided, in the main, by a supernumerary team leader who worked at the home 5 days a week solely in the interest of providing staff support and feedback through care practice observation. Records showed that 10 staff had benefited from care practice observations and feedback in September 2016.

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

We checked 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 found that one of the people who lived at the home was subject to a standard DoLS authorisation and another was subject of an application being made. We were able to view the paperwork in relation to the standard authorisation and the application for a standard authorisation. We see that mental capacity assessments and best interests' decisions had been recorded on each file.

The standard authorisation had lapsed on 16 September 2016 and an application for a renewal had been made on the 7 September 2016. This application was late. The managing authority which is the provider SCOPE has a duty under the MCA to determine whether or not a further application is required at least 28 days prior to the expiry date. We were told that the system for recording when DoLS authorisations were due for renewal was automated but this had not been passed on to the new manager when they took up post. The respective supervisory bodies had written to the home in respect of each application and advised that they had both been put on hold pending allocation as both were considered low priority.

Staff told us that they had received training on MCA and DoLS. They were aware as to who was subject to DoLS but their understanding of the MCA and what a mental capacity assessment comprised of was limited. For example they were unfamiliar with the two part test, that MCA assessments must be decision specific and any decision made in a person's best interests must be the least restrictive. All staff presented with a good understanding of the design and purpose of the MCA in as much as they knew it was to help people who lacked capacity to make decisions themselves and as far as they are able and that when decisions are made on a person's behalf they can only be made in that person's best interest. The training matrix showed that most staff had received training on the MCA and DoLS however managers told us that they were aware this was an area that needed further development and as such further training was being sought.

During our visit we saw that staff took time to ensure that they were fully engaged with each person and checked that they had understood before carrying out tasks with them. Staff explained what they needed or intended to do and asked if that was alright rather than assuming consent.

The provider had their own induction training programme that was designed to ensure any new staff members had the skills they needed to do their jobs effectively and competently. We looked at the induction records for the most recently appointed staff member and saw that it was based upon the Care Certificate.

This is a new nationally recognised qualification which superseded the common induction standards. It is an identified set of standards that health and social care workers should adhere to in their daily working life. It includes topics vital to each member of the workforce such as safeguarding adults, basic life support, health and safety, communication, person centred care, and equality and diversity. All care staff were either working towards the Care Certificate or had achieved a vocational qualification. The training matrix showed that five staff had a vocational qualification at level 2, another five had attained level 3 and one had attained level 5.

A tour of the premises was undertaken, which included all communal areas including the lounges and dining rooms and with people's consent a number of bedrooms as well. The home was decorated in a homely fashion and people had been enabled and encouraged to decorate their bedrooms to reflect their personal aspirations and characters. The home was equipped with aids and adaptations for use by people who needed additional assistance. These included ceiling hoists bath and toilet aids, grab rails and other aids to help people maintain independence.

The home was clean throughout and communal toilets were equipped with paper towels and liquid soap in the interest of infection control and staff had access to personal protective equipment as required.

Good

Is the service caring?

Our findings

The atmosphere in the home in each bungalow was relaxed and sociable throughout our inspection. The people who lived at the home were well presented, dressed in well laundered clothes that reflected their personal tastes and styles. They all had smiles on their faces and all had something positive to say about the staff and the way care was provided. One person said I am very happy here and two other people said they "loved it". Another person showed us that they had acquired an "I pad" which had a programme designed to support effective communication. Using this supported by speech they told us that they were happy, that the food was good and that they loved the home and the staff.

As we had seen on previous inspections there was a lot of laughter, hugs and expressions of affection, cheery hellos and good byes which made for an extremely pleasant and welcoming atmosphere. Staff were kind and caring in their approach and were seen to respond to people's moods, demeanours, physical and emotional needs in a positive, supportive and engaging manner. When people needed assistance we saw that staff approached them sensitively, discreetly asking them if they needed assistance.

We could see that staff respected each person's personal preferences and promoted positive choice. One person told us that staff knew and respected their personal preferences and said "they know I like a soak in the bath in privacy and they respect that". People rose and retired at a time that suited them, chose what they wanted to eat and where they wanted to eat it. Staff always knocked on people's bedroom doors and waited to be invited in before opening the door.

There was no doubt that interactions between staff and the people who lived at the home were based on a foundation of mutual respect and a desire on staff's part to involve the people and empower them in all aspects of daily life. There was one isolated incident where a member of staff had responded defensively when a person made a negative comment about activities and then proceeded to ignore the person. This was addressed by the management team through a supervision meeting with the member of staff in question.

As part of our inspection we contacted a number of community based health and social care professionals and asked them for their views on the standard of care provided at the home. They told us that communication was improving and managers and staff were working with them to develop effective arrangements for the care and support of the people who lived at the home.

The quality of decor, furnishings and fittings provided people with a homely and comfortable environment to live in. People's bedrooms were personalised and contained photographs, pictures, ornaments and the things each person wanted in their bedroom.

The provider had developed a range of information, including a service user guide for the people living in the home. This gave people detailed information on such topics as medicine arrangements, telephones, meals, complaints and the services provided.

We saw that personal information about people was stored securely which meant that they could be sure that information about them was kept confidentially.

Requires Improvement

Is the service responsive?

Our findings

When we carried out our last comprehensive inspection of the home we found that the service was not always responsive. Person centred care planning, monitoring and review, had been introduced to the home but staff did not always understand their roles and responsibilities and staff shortages had impacted on the staff teams' ability to meet peoples' needs in accordance with agreed plans.

The people who lived at the home told us that things had improved. They said they were happier because there were more staff which meant there were more opportunities to get out of the house and take part in ordinary activities such as shopping, going to the cinema and local cafés.

In response to the concerns we raised the provider drew up and implemented a recovery plan which included several action points on the management, training and development of staff including direct supervision, observation of their practice and competency assessment. We found that shortfalls in staffing had been improved and staff were benefiting from close supervision, support and direct feedback on their practice. However, we identified failures in the planning and delivery of care which had put people's safety and well-being at risk.

People told us and we could see from their records that they were involved in planning their care and support. Person centred care plans, known as PCPs, had been re-written for all the people who lived at the home in August 2016 but had not been effectively evaluated to ensure they were fit for purpose and that they underpinned effective arrangements for care and support of the person. For example one person's PCP omitted up to date guidance on what action staff should take in the event they suffered constipation. This had resulted in the person's health care needs not being met. The person's bowel chart showed no bowel movement for in excess of 8 days from the 30 August 2016. Health care records showed that staff did not contact the person's doctor for advice until the 8 September 2016. This was contrary to written guidance found in their care records which had been provided and signed by their doctor 16 August 2016. Staff including the area manager and the new manager were unaware of this guidance because. Similarly the same person's PCP omitted guidance provided by their dietician in July 2016. We found that staff were unaware of this guidance were not following it and had not responded effectively when the person suffered significant unintended weight loss.

Another person's PCP was not updated when their assistive technology communication device a "GoTalk" was found to be inoperable. When asked about it a staff member told us that they had never seen the person's "GoTalk" since the end of June 2016. Records showed that the matter had been reported to the speech and language therapy team (SALT) in early August but there was no record of the outcome. When we asked staff as to the whereabouts of the "GoTalk" they were unable to say and it was only when another service user told staff where it had been put away that it was located. We contacted the SALT team on the 22 September and were informed that their representative had visited The Hollies on 19 August and advised staff that the "GoTalk" needed to go back to the manufacturer for repair. This was not recorded in the person's care records care or on their PCP. This omission in basic care planning left this person without a vital communication aid for over three months. The format of the PCP does not allow for them to be easily

updated when a person's condition and therefore needs change.

The issues above constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care. In that the registered person failed design plan and deliver care that met peoples needs.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. Easy read guidance on how to raise concerns was detailed in each person's personal care files. The home did not maintain a hard copy file for complaints as all complaints were loaded onto the providers computer system which we were given access to. We found that there were only two complaints listed that related to The Hollies. One was dated 2014 which was addressed and acted upon. The other from a service user dated April 2016 had not been investigated or responded two according to the records. The area manager told us that the staff member the complaint was about had left the home's employment but this did not provide a satisfactory explanation as to why this complaint had not been investigated or responded to. We were aware that a relative of a service user had made a complaint on their behalf. This was not recorded on the provider's computer and the complainant told us that they had not received a satisfactory response to the concerns they had raised.

The issues above constitute a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints. In that the registered persons had not always investigated and responded to complaints in accordance with the established procedure.

We found that the atmosphere in each of the three bungalows had much improved and at times was positively vibrant with fun and people engaged in a range of activities, or coming and going from activities in the community. There were times when the atmosphere was more relaxed reflecting the moods and temperament of the people who lived there but was always welcoming and sociable. We saw staff reinforcing people's rights, involving them in decision making and empowering them in all aspects of daily living.

Inadequate

Is the service well-led?

Our findings

At our last inspection February 2016 we found that the registered manager had not taken effective action to address care practice failings identified at our previous inspection in October 2015 inspection so vulnerable people had remained at risk of receiving unsafe care.
We took enforcement action in line with our enforcement procedures cancelled the manager's registration and put the service in special measures.

In response to our findings the provider (SCOPE) took action to address fundamental inadequacies in the management and conduct of the home that had been identified by the Commission, the local authority contracts monitoring team, community based health and social care professionals and their own internal quality assurances processes. An action plan known as a recovery plan was designed and implemented to bring about the required improvements in care practice and to ensure that staff received the guidance, training, support and leadership they required to conduct the service in accordance with the provider's values and beliefs. The management team including team leader, registered manager and area manager was replaced with interim managers and in August a new team leader, manager and area manager was appointed.

We could see that the registered provider had invested heavily in the improvement and recovery plan. The homes quality assurance systems had been strengthened. A mock inspection was carried by the provider's quality assurance team in April and May and a further mock inspection was carried out in July 2016. The Quality Manager completed a further quality audit known as the Quality Assurance Framework verification visit which identified that improvement had been made but rated the service as insufficient overall. Prior to our inspection we met with the provider's representatives including a senior manager and the nominated individual. They told us that their internal enquiries had found that the home had been poorly managed for a number of years. The consequences of poor management had resulted in poor outcomes for the people who lived at the home and a disempowered staff team who had lacked the required confidence and skills to carry out their duties and responsibilities effectively. They informed us that their internal quality assurance procedures had resulted in significant improvements in the management of staff with improved outcomes for people who lived at the home. However, and it is important to note that they were clear with us that whilst much had been achieved since February 2016 they were aware that there was still room for improvement.

We found that significant improvements were being made in some aspects of service delivery and care but also identified further breaches of the relevant regulations in respect of safe care and treatment, eating and drinking, staff training and development, person centred care, and safeguarding vulnerable people from abuse and consent to care. We could see that staff were carrying out various audits and checks in the interests of identifying and rectifying issues but there was confusion regarding what checks needed to be done and when. For example quality checks had been instigated on pressure relieving mattresses to ensure they were set correctly but staff had stopped doing them for reasons that the manager was unable to explain. This lack of basic audit had resulted in people being put at risk of developing pressure sores. When we checked five pressure relieving mattresses we found that all were set at incorrect settings. The team

leader told us that he had tried to resolve confusion about the checks senior support workers were responsible for but we found omissions including handover records not checked since 19 September 02 October 2016, Weekly Fire alarm checks not recorded since 02 September 2016 and medication stocks counted but not correlated with medication administered.

Monthly audits had been carried out on service users' personal finances but had stopped in May 2016, for no apparent reason. When we checked them on the 19 October we found minor accounting errors, missing receipts and expenditure which had been adequately accounted for.

Following the first two days of our inspection on 21 and 23 September 2016 we wrote to the nominated individual to confirm our findings including incidences where staff had failed to respond to service users' changing needs. On the 17 October 2016 we received a written notification informing us that another incident had occurred where a person's health care needs had not been met because staff had failed to adhere to written guidelines on the administration of medicines. This showed us that managers and staff were not learning from adverse events the providers so vulnerable people remained at risk of their needs not being met.

The above issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.

The service was placed in 'Special measures" 03 May 2016 following our inspection February 2016. Because the overall rating for this service will remain as 'Inadequate' the service will therefore remain 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 is made within this timeframe so that there is still 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 if they do not improve.
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.