9 Grace Road Ltd

9 Grace Road Limited - 9 Grace Road

Inspection report

9 Grace Road
Leicester
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We inspected 9 Grace Road on 4 and 5 November 2015 and the visit was unannounced. We last inspected the service in July and August 2015. At that inspection, we found breaches of legal requirements in four areas; the reporting of incidents and accidents, assessing risk, good governance and safeguarding people who use services from abuse. That meant the service was placed in special measures. We asked the provider to take action to make improvements however they had not time to send a dated plan by the time we re-visited in November. On this visit we found that there were continued breaches in assessing risk, protecting people from harm, providing safe care and good governance. There were further breaches in failing to provide statutory notifications, medicines administration and providing adequate infection control.

Summary of findings

The service does not have a registered manager. Following our visit in July the Registered Manager resigned, a manager is now in post and intends to register with the CQC when the appropriate legal clearances have been received.

The provider has commenced sending us notifications about events happening to people living at the home. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

Risks to people's health and safety was not overseen, managed or reviewed. We found a number of infection control issues throughout the home.

There were sufficient numbers of staff to keep people safe and meet their needs, and staff went through a thorough employment process and were recruited safely.

The legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were now being followed. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. The DoLS safeguards ensure that people are not unlawfully restricted.

Staff provided a varied response in dealing with behaviours that challenge, and not referring to people with their chosen name.

People's privacy and dignity were not upheld or respected.

People were provided with meals that met their cultural and dietary needs. Nutrition was monitored by appropriate health professionals.

People were given greater choice on how they spent their time, as an activity co-ordinator had been employed and made improvements for people's cultural and spiritual wellbeing.

People's care plans included personalised information about their individual preferences and communication passports reflected how people could be communicated with on an individual basis.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

We noted a number of changes and improvements through the inspection, however the majority of these were reactive and limited to the deficiencies reflected in the last report.

There was limited information relating to people's health needs and associated risks with diagnosed conditions. The health action plans which we saw at the last inspection had been removed from the care files.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

Summary of findings

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.

Risks to people's health and safety were not managed and reviewed.

People who declined their medication needed a clearer protocol in place to ensure an effective dose of medication was administered to ensure that prescribed level was maintained.

There were sufficient numbers of staff to keep people safe and meet their needs.

Staff went through a thorough employment process and were recruited safely.

We found a number of infection control issues throughout the home which placed people at risk from acquired infections, through cross infection or cross contamination, and areas of the home were unclean.

Is the service effective?

Inadequate

The service was not effective.

Monitoring of medical interventions and health care services were still not undertaken robustly to protect people from harm.

Staff were now aware of the requirements of the MCA and DoLS, and the appropriate monitoring was being undertaken.

There was inconsistent recording between care plans, daily records and staff handover information.

People were provided with meals that met their cultural and dietary needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not always spoken with in an appropriate way.

People were not always addressed by their preferred name.

People's privacy and dignity was not upheld or respected.

People's future and decision making was supported by family members or advocates.

Is the service responsive?

Requires improvement

The service was not responsive.

People's healthcare was not properly assessed or planned for.

People still did not receive the care and support in an individualised way.

Summary of findings

People that required support and intervention were not responded to in a consistent manner.

There had been improvements in individual activities that recognised people's cultural diversity.

People were still not supported to maintain or build on their independent living skills.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not arrange for the appointed director or staff to ensure an effective overview of the home and take action as needed.

Effective systems were not in place to assess, monitor and improve the quality of care.

Broken equipment was not being identified or repaired by the provider.

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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 4 and 5 November 2015, and was unannounced. This followed previous inspections on 16 and 17 July 2015, 6 August 2015 and 19 August 2015.

The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home and information from the local authority commissioners and the police.

We had received four notifications from the provider since the last inspection. A notification is information about important events which the service is required to send us by law.

During the inspection we spent time observing the care being provided throughout the home. We observed people being supported at lunch time and at other times in the home. We spoke with the manager, the deputy manager, a senior carer, three care workers, and a domestic / care worker.

We looked at records relating to all aspects of the service including care and staffing, as well as policies and procedures. We also looked in detail at three people's care records and the recruitment files of three care workers.

The provider has employed a person to manage the service. As this person was new in post, we allowed them time to check and send the policies, procedures and Statement of Purpose that were not available on the day of our visit.

Inadequate

Is the service safe?

Our findings

At our inspection of 16 & 17 July 2015, 6 & 19 August 2015 we found provider did not ensure reportable incidents or accidents were sent to CQC. This was a breach of Regulation 20(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan, which was not due until we re-visited on 4 & 5 November 2015 to see if improvements had been made and people were safe.

We found the provider had arranged for staff to send notifications. We received four of these which were about issues that had affected people living in the home. Those that were required to be reported on to the appropriate authorities had been done so. This ensured that any appropriate action could be undertaken if required.

At our inspection of 16 & 17 July 2015, 6 & 19 August 2015 we found the provider failed to make sure people who used the service were safe from the risk of harm. This was a breach of Regulation 12(2)a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were not able to tell us if they felt safe. Some of the people who lived at the home had limited communication so we were unable to obtain direct verbal feedback about their experiences. We made a number of observations throughout the inspection which has informed this report.

Staff knew how to recognise the signs of abuse and were able to tell us what the different types of abuse were. Staff we spoke with were able to explain the different types of abuse and the action needed if they suspected abuse had taken place. Staff knew about the safeguarding protocols and processes for reporting abuse to external agencies such as the local authority or police. Staff were also aware of whistleblowing, and who they could contact with information of concern.

Staff were aware of the whistleblowing procedure and all staff spoken with said that they felt they could raise concerns with the manager, their deputy or the provider representative when they saw them.

The provider employed a consultancy company who assisted with updating the care plans, risk assessments and companies' policies and procedures. They informed us that the safeguarding and whistle blowing policies had been updated, and we were sent the latest versions of these following the visit.

We found that people's care plans had been updated and these had improved to give a clearer picture of people's care needs. The overall number of files had been reduced making it easier for staff to ascertain people's needs and parts of the care plan or risk assessments that had been updated. However the health action plans had also been removed which placed people at risk as staff did not have up to date personalised information about people's health needs.

Risks to individuals had been assessed as part of their care plan. This included the risks to people's mobility, developing pressure wounds and risks associated with behaviours that may challenge. However we saw that staff did not always appear to understand the measures that were needed to be taken to reduce these risks. For example, we observed staff supporting one person to transfer from an armchair to the dining area using a walking aid. The seating was inappropriate for the person and was so low the person had to make several attempts to achieve a standing position which caused them some distress. The person clearly told staff that they did not want to return to the armchair after their meal as it was too low. However, we saw that when staff supported the person to transfer from the dining area, they returned them to the chair that was too low with the result that the person fell backward into the chair from a standing position. This put the person and staff at risk of injury.

The provider had failed to make sure that risk and staff actions had been thoroughly assessed to protect people from harm and ensure their safety. This was a continued breach of Regulation 12(2)a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection of 16 & 17 July 2015, 6 & 19 August 2015 we found provider did not safeguard service users from abuse and improper treatment. This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the risk assessment for a person with an enduring health need that required continual monitoring. There was guidance for staff to look out for additional symptoms and these were listed. However there was no

guidance for staff on the lower or upper limits of where the results of the monitoring should fall, nor was there information about the follow up process and involvement of any health professionals. We looked at the monitoring of this persons health condition. We saw that on seven occasions in a period of 34 days there was only monitoring performed by staff on one occasion daily, and on one further occasion there was no record made. When we looked at the supporting staff records, we found the night shift had reported at handover the person had been 'weak and can't balance properly'. When day staff completed their monitoring test they took the appropriate action that had been agreed by the specialist health professional. We found that the staff failed to recognise the combination of issues, and any follow up organised by the provider or manager. That meant the person was placed at risk due to staff not having a consistent procedure to follow.

We noted that there were no health action plans with people's care plans. These were in place at our last visit, and the manager told us these had been removed to be updated. This did not assist the care staff in providing a consistent approach to maintain people's health care.

Some people had risk assessments for their finances. Assessments recorded that people were vulnerable from financial abuse due to not recognising the value of money. Measures to prevent abuse included restricted access to monies, day to day expenditure and internal auditing. However, assessments did not show a protocol for authorisation for large expenditure and what financial limit in terms of expenditure was acceptable before any referral was made for external authorisation.

The provider had failed to safeguard service users from abuse and improper treatment.

This was a continued breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager who assured us safety checks had been undertaken throughout the home. We recognised there had been improvements on the paperwork for people having their bedroom doors locked at night. However there had not been any changes to the type of bedroom door lock, and these still had the facility to be 'dead locked'. That meant people could inadvertently lock themselves in their bedroom with no easy means of the door being opened, or escape in the event of an emergency. This meant that people's safety was potentially put at risk.

We undertook a safety check around the building as we were not convinced safety checks had been undertaken and the outcomes reported to the manager. We did a check on the day that revealed that there was an electric hoist that was not working, which had been serviced three weeks prior to our visit, but not reported by the staff for repair. This was the only hoist that enabled a person who used the service to get in and out of the bath.

We also found call bells that were not accessible due to being behind bed frames, and others where the wire was too short to enable a person in bed to use them. There was a broken low level light fitting which was accessible by the person, laminate flooring that had started to separate and was a trip hazard and the odour of urine in a corridor and two bedrooms. None of these had been recognised in the checks that staff performed, or reported on to the manager. That meant people were placed at risk from ineffective performed staff checks.

We observed a staff member administering medicines at lunchtime. They followed safe procedures and completed the medicine administration record (MAR) charts once the person had taken the medicine. We saw that the name and photograph of each person was on the monitored dosage packs which meant people could check and give people the right medicine.

We observed staff talking to people and explaining what they were giving them. They were patient and made sure that people had a drink with their medicines. We saw that one person regularly declined their medicines. There was guidance within the person's care plan for staff to follow in the event of the person declining their medicines. Following consultation with the person's GP, the guidance stated that staff were to approach the person again a short time later. We were told that staff had made several attempts that day to encourage the person to take their morning medicines and these were re-offered and taken by the person at lunchtime. There was a need for an updated protocol to ensure that stated the maximum time that medicines can be re-offered. This was to ensure the medicines were taken safely and the dose remained at an appropriate level, and in line with the next time they were prescribed.

Inadequate

Is the service safe?

We saw other medicine protocols had been put in place for 'as required' medicines. We saw up to date protocols for medicines to support people who had epilepsy. However, some medicines that were prescribed as and when required did not have a protocol for staff to follow.

We saw that where topical medicines were prescribed, the medicine care plan did not always have a body map or instructions on the medicines administration record to show the areas where the topical medicine should be applied. Body maps were referred to as being essential in people's care plans, but none were in place. That meant people were placed at risk of harm from staff that did not have specific instructions to enable them to apply these medicines accurately. This is another example of care plans not being used to ensure that people were receiving safe care, support and treatment to meet their identified needs.

The senior care staff on each shift was responsible for giving medicines. Staff told us that they had recently received updated training on medicines as the service has moved to a new pharmacist and monitored dosage dispensing system. Medicines were stored safely in a designated locked room. We found medicines kept in the fridge were regularly checked and stored within the recommended temperatures. However, there were two temperature charts in use and there were gaps in recording due to staff confusion as to which record to use. That left the potential for medicines to be stored at temperatures that would not ensure their potency, and so leave people at risk of medicines with insufficient strength.

The senior carer was responsible for recording the temperatures medicines were stored at. We looked at the policy and procedure for medicines. This did not state how staff should record the checks, the frequency or the procedure if the temperatures were found to be outside safe limits.

We asked to see the medicines return book. Staff were unable to locate this at the time of our visit and there was a large amount of stock waiting to be returned to the previous pharmacist. There was no evidence of any checks by the manager to ensure people were supported to take their medicines safely. Staff told us that managers check records and stock at the end of the month's supply and the deputy manager carried out spot checks on practices but there was no evidence of this.

The provider had failed to ensure proper instructions were in place to enable medicines to be administered accurately and at appropriate times. This was a breach of Regulation 12(2)g of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we found that the use of restraint had continued to be detailed in a number of people's records. We saw there had been a number of best interests meetings arranged and deprivation of liberty safeguards [DoLS] applications made on peoples' behalf. The local authority had agreed restrictions to people's liberty, and these were now reviewed on a regular basis.

Individual personal fire evacuation plans had now been completed and we saw copies in the files we looked at. We also copies of these in the fire box situated at the front door of the home.

We asked the manager for the fire safety checks but they could not produce the folder, as they had been given to the company checking the fire and evacuation system to produce some follow up documentation. We were contacted by the fire authority who had visited to ensure the updates they specified at their last visit had been put in place. They agreed that improvements were in place and had viewed the fire alarm tests at their visit. That meant the provider had ensured progress had been made in this area, and the home was complaint with the fire regulations.

There were six care staff members on shift in the morning and five in the afternoon, and two waking night staff overnight. There was also a cook and housekeeper employed on a daily basis.

Staff told us that agency staff were being used less regularly. The manager told us they had recruited a number of permanent staff and were awaiting the last of those to commence in post the Monday following our visit. They explained that would reduce the need for agency staff and provide greater consistency of care for the people living at the home.

Since our last visit the provider had implemented a more consistent recruitment process to ensure people's safety. Recently employed staff had completed a check with the Disclosure and Barring Service (DBS) before starting work. We looked at three staff recruitment files, and all of those

Inadequate

Is the service safe?

had the appropriate pre-employment checks in place. We also saw where people had undertaken induction training and were placed with permanent staff for an introduction to the service.

The provider had not ensured that people were kept safe from the risk of infection. Some areas of the premises had unpleasant odours such as corridors by bedrooms. Some of the seating in the lounge and dining areas smelt offensive and were in need of replacement or deep cleaning.

We also looked at the storage of cleaning materials in the laundry area, which were stored safely behind a locked door.

We saw that gloves, aprons and hand sanitizer were available. Liquid soap and paper towels were also available. That meant that staff were able to protect people from the risk of cross infection.

We looked at the storage cupboard for cleaning materials which was appropriately locked. There were adequate supplies of cleaning materials, though the domestic cleaner on duty was not familiar with the control of substances that are hazardous to health (COSHH) processes and the safety around handling chemicals safety. That meant people were placed at risk of chemicals being used or handled inappropriately. We noted there was no back up COSHH data or written information for staff, to instruct them what to do in an emergency.

We looked at the COSHH policy and procedure which was not detailed enough to guide or instruct staff to ensure peoples safety.

We asked the member of staff about the different coloured mop heads, they were able to tell us which colour related to a certain area of the home. However there was nothing in the policy or procedure to confirm that, which meant there was no definitive guidance for staff that ensured the process was carried out safely.

We asked the member of staff about how the mops were disinfected. They stated they were washed in a washing machine. However the explained this was done on a 'warm' wash which was not sufficient to ensure they were disinfected appropriately. That meant there was the potential for cross infection and cross contamination to be spread throughout the home.

We found that people's files had been updated to reflect significant risks such as those associated with known blood borne health conditions, however these were not reflected in the policy for infection control in the home.

The policy for cleaning was partly detailed and informed staff how to reduce the likelihood of cross infection or cross contamination and needle stick injuries. However there were no cleaning schedules, no procedure to explain how to disinfect or store the mops appropriately. That meant there were no set processes to enable staff to consistently provide the appropriate levels of disinfection throughout the home and keep people safe from infections.

This was a breach of Regulation 12 (2)h of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment and transfer of infections.

Inadequate

Is the service effective?

Our findings

At our inspection of 16 & 17 July 2015, 6 & 19 August 2015 we found people were at risk of care that was not safe, effective or that met their needs.

This was a breach of Regulation 12 (2)a of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that staff had recorded a person had a fall that resulted in a head injury, and required a paramedic visit. We noted that the person also received twice daily blood monitoring for their diabetes. We looked at the period between 3 October and 5 November 2015 and the records staff had completed. On seven occasions between those dates monitoring was only recorded on one occasion, and on 30 October 2015 the date was recorded, but no information had been entered. When we looked at the corresponding night staff report the staff had recorded the person had been unwell in the night and was 'unsteady on their feet whilst being assisted with personal care'. The first recorded health monitoring of the following day indicated a low blood sugar result, and staff took appropriate action to rectify the outcome. However neither the night staff's report or day staff's monitoring result had been reported on to the manager or deputy. That meant the person was placed at risk from staff not proactively following up their health needs, which for someone with diabetes places them at significant risk.

There was a further issue for the same person earlier the same month where they had a fall. There was confusion in the accident recording and health monitoring where the dates were not consistent with the reports by the visiting health professional and again there appeared to be no health monitoring recorded on 21 October 2015.

The CQC reported these concerns directly to the safeguarding coordinator at the local authority so that these could be investigated appropriately and any follow up actions be put in place.

We spoke with staff who were aware of the lower limit that the monitoring should not have fallen below, and what they needed to do in the event of such a result. We also saw where staff had taken relevant action to enable the person's health to be stabilised. This person's health was being monitored regularly but there was no consistency applied to the process overseen by management to ensure an effective service. Neither was guidance in place for staff to deal with results out of the expected normal range.

The provider had failed to provide care that was not safe, effective or that met their needs. This is a continued breach of Regulation 12 (2)a of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection of 16 & 17 July 2015, 6 & 19 August 2015 we also found people staff did not understand the requirements of the Mental Capacity Act 2005 and had not fully introduced either the principles or the appropriate documentation into the home.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 is legislation used to protect people who might not be able to make informed choices on their own about the care and support they receive. At this inspection we found that staff did understand the requirements of the Mental Capacity Act 2005 but had still not fully introduced either the best interests principles or the appropriate records into care files.

There were a number of people who lived at the home who lacked capacity to make informed choices and decisions. We saw a number of best interests decisions that had been made for these people, by a consultant who worked for the home. However the information about the decisions did not include how the decision was reached, what the reasons were for the decision, or who was consulted to assist in the process or what factors were considered. That meant that decisions were being made for people without adhering to legal principles and were made in isolation.

A number of people who had restrictions placed on their freedom and liberty have now had deprivations of liberty safeguards (DoLS) authorised. The manager made us aware that four DoLS had been agreed and were being monitored by an appropriate person from the local authority. However this was after a significant period of time, as the provider had failed to inform us through the appropriate notification process these had put in place.

We were also passed information from a health professional where DoLS authorisations had been agreed, but the provider had failed to monitor any changes. These

Is the service effective?

included information that required the provider to action further health reviews. These were health referrals that required a specialist follow up. For example, wheelchairs which were not meeting people's needs and people not having specific positioning plans for lying in the 'comfy' chairs. That meant peoples care did not meet their postural needs and that contributed to deterioration in individuals posture.

This was a breach of Regulation 18 (4A) and (4B) of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to inform the CQC that DoLS restrictions had been placed on four people in the home.

The manager had implemented a new shift handover system to improve incident recording and communication between staff. The new system was used as a quick reference guide for staff in terms of monitoring practices such as staffing levels and responsibilities, tasks allocated, medicines, manual handling and incidents. This record was used alongside each person's daily records which recorded their general well-being.

We saw that these records were not being completed consistently by staff. For example, one handover sheet referred to an incident involving a person and yet there was no reference to the incident in the person's daily notes or in any part of the care plan. It was not possible to find the nature of the incident or ascertain if the staff had responded appropriately to the incident, or if the person's health and well-being had been at risk. In another person's daily record, recordings referred to an incident that required the person to be on bed rest and receive a doctor's visit. However, we could not find any evidence of the actual incident that resulted in this action. That meant that essential information could potentially get lost which could put people at risk or ensure they were not effectively supported.

We looked at the training matrix which had been updated. The plan had also been amended to signify where people required their knowledge to be brought up to date, but as yet there was no plan in place to clarify when the updated course had been scheduled.

Staff told us that they continued to receive regular supervision and they thought that these sessions were useful in providing a quality service. These had commenced with the consultancy company and had continued with the manager and deputy manager both undertaking planned sessions. The manager told us it was one way of getting to know the staff better, and assisted with planning follow up training.

People were provided with meals that met their cultural and dietary needs. We saw that people appeared to enjoy the food provided. Records showed that an assessment of people's nutritional needs and plan of care was completed which took in account of their dietary needs.

People's weights were measured and recorded regularly. Where concerns about people's food or fluid intake had been identified, they were referred to their GP and other medical professionals such as dieticians and speech and language therapists. Information in care plans detailed people's dietary needs, the assistance needed or any specialist equipment required. For example, one person's care plan identified that they needed help to eat and drink and another required meals suitable to manage their health condition, such as diabetes. We saw that people were provided with support through prompting, handover guidance and full support during lunch time. We also saw specialist equipment being used, such as adapted cutlery and lipped plates which supported people to eat their meals as independently as possible.

People's care records showed that people had been supported to attend medical appointments and that some of their health needs had been identified and entered into the care plan. However, recordings were very fragmented and it was not easy to track a person's medical history or appointments for a specific medical need. People did not have health action plans within their care plans. That meant that, although specific health needs had been identified as part of the assessment process, there was little evidence that the service responded effectively or consistently to meeting individuals health needs.

There was limited information in care plans relating to people's health needs and associated risks with diagnosed conditions. The health action plans which we saw at the last inspection had been removed from the care files. We spoke to the manager about this who said they had been removed to be updated. That meant that due to this limited access to information staff members that did not have historical knowledge of people's conditions may not have been fully aware of the risks that came from people's enduring health needs.

Requires improvement

Is the service caring?

Our findings

We saw that staff knowledge and understanding of caring for people with learning disability and behaviours that can challenge varied. Staff told us that they had received training in communication passports and managing behaviours that may challenge. However, our observations showed that some staff did not understand how to support people whose behaviours that challenged. One member of staff clearly struggled to manage a person's behaviour who consistently took drinks from other people. The staff member attempted to wrestle a drink from the person and then proceeded to tell them that they had been 'naughty'. We saw that the staff member had not followed the behaviour management guidelines outlined in the person's care plan.

We saw another member of staff show timely intervention to the same person and prevent the person taking drinks through distraction techniques. This was in line with the person's behaviour management guidelines. The manager told us that staff had been trained though these staff were new to the service.

We saw staff had organised a trip out for one of the people who lived at the home, and was in the process of organising further visits to culturally appropriate venues. That showed that people's diverse needs were taken into consideration. We were also aware that some of the other people had just returned from a holiday to the seaside. This meant that people's individual diversity had been recognised when arranging leisure activities.

We saw that people's continence aids were stored openly in the first floor communal bathroom. Each pack was labelled with peoples initials, identifying the person for whom the aid was intended. This did not preserve people's right to privacy.

We observed one person make a gesture of putting a finger in their mouth and making a noise. When we asked staff what this meant, staff responded that they did not know, and told us that they had never seen the person make this gesture before. We saw that staff did not approach the person to find out their needs or check on their welfare.

We saw that one person used Makaton to communicate some of their needs. We saw staff using this method of communication. Staff told us that since using this form of communication the person's behaviour was less challenging. They gave examples where the person was more accepting of unplanned situations occurring. We looked at the person's care plan. However, this had not been amended to reflect how staff could better communicate the person, nor had their care plan been reproduced using pictorial prompts. That meant staff had begun the process of more personalised communication with people but this has not been expanded to ensure staff were always caring in their approach.

Some people who lived at the home were referred to by a shortened version of their name. Whilst this was done in a caring way, we found that this was not line with how people preferred to be addressed, which was recorded in people's care plans.

We saw some staff members that demonstrated a caring attitude. They interacted calmly and politely with people and demonstrated genuine concern for people's wellbeing.

At our last visit we saw that people did not have an appropriate family member or an advocate to represent their views. An advocate is a trained professional supporter, to enable and empower people to speak up, or represent their views. At this visit we saw that an advocate had been engaged for a number of people who lived at the service. We also saw where people had increased contact with their relatives, who also acted on their behalf and assisted with planning their future. That meant people had received assistance, independent of the staff group, to ensure their opinions were taken into consideration designed to ensure that future care could be planned appropriately.

Requires improvement

Is the service responsive?

Our findings

Care was not always delivered in a personalised way to people. During our observations throughout the day, we found there were set times for tasks that staff carried out such as providing drinks and meals.

We saw that when one person asked for a cup of tea a staff member told them they would get one soon when everyone else had their tea. That was at the next time the drinks trolley was brought round. We saw that at times people were treated as a group rather than individuals which did not promote people's sense of identity and wellbeing. For example, we saw that one person was supported to eat a late cooked breakfast after getting up later in the morning. We observed the same person being supported by staff to eat a two-course lunch a short time later. The person did not appear interested in their meal and staff did not question if the person was actually hungry or preferred to have their meal at a later time. We heard the staff member ask the person if they were 'having a lazy day'. This did not provide care responsive to people's needs. We spoke with the manager about this and they agreed that they would speak with the staff.

We saw there were no health action plans included within the care plans. We spoke with the manager who told us that they had been removed to be updated. That meant that people's health was not reflected in their care plan, and staff did not have up to date, individual or complete information about people's health needs. That meant staff that had been employed recently and did not have a detailed knowledge of people may not recognise the signs of a person becoming less well or behaviour that required intervention before it escalated.

There had been improvements in the way people were given choices on how they spent their time. An activity co-ordinator had been employed at the service. They told us that they worked flexible hours to support people to join in activities in the service and the local community. This included swimming and accessing the local community.

We saw one person supported by a member of staff to purchase Indian sweets from the local shops to celebrate Diwali. We observed a group of people supported to make Christmas cards during an arts and craft session. The activity co-ordinator was able to tell us about a recent holiday to Butlin's for three people who used the service. One person told us they had really enjoyed their holiday and couldn't wait to go again.

However people were still not supported to build on their independent living skills. For example, people were still not given the opportunity to be involved in cleaning their home or bedroom, cooking, washing their clothes or planning meals. Although people may have been able to complete a task alone with support they could still be involved in tasks to help respond to promoting independent living skills and confidence.

People's care plans included personalised information about their preferences, for example what time they liked to get up and whether they preferred a bath or shower and when. People's personal life history and experiences were recorded in the care plan, included their preferred terms of address and likes and dislikes.

Each person had a communication passport which provided guidance to staff on how to communicate with each person and how to respond to non-verbal communication. For example, one persons' care plan emphasised the need for staff to observe non-verbal indicators to identify if the person was happy, in pain, cold or did not wish to interact. It guided staff on the most appropriate response.

Another care plan referred to a person using objects of reference and gestures to communicate. We observed staff communicating with people in their preferred form. For example, one person signed using methods unique to them. We saw that staff respected this to ensure communication was effective.

There had been improvements to the recording of how staff reacted to people that presented behaviour that challenged. We saw in some care plans specific records such as 'ABC' charts. These record the actions, behaviour and consequences of people and their interactions with others in the home and the staff group. These can then be used by health professionals to monitor behaviour over time, and plan effective care responding to this information.

We observed one person who regularly presented with challenging behaviour. Staff were not consistent or

Requires improvement

Is the service responsive?

responsive in their approach in dealing with the initial behaviour of taking drinks. This inconsistent approach by staff has the potential to have generated further behavioural issues for this person.

There was a complaints procedure for people in the foyer of the home near the door. This has still not been re-produced in an accessible format. The document has been updated since our last visit, and now has the appropriate contact details for the Care Quality Commission (CQC). We asked the manager if there had been any complaints since our last visit. They indicated there had been no formal complaints but they were in the process of recording "niggles". We understood these to be 'grumbles' and criticisms made by people in conversations. The manager explained these are to be logged and any outcomes or resolutions recorded as well, but as yet there were none recorded. This meant there was no evidence whether the service effectively responded to people's concerns in these instances.

Inadequate

Is the service well-led?

Our findings

At our inspection of 16 & 17 July 2015, 6 & 19 August 2015 we found the provider had failed to make sure quality assurance systems were in place to ensure that risk had been thoroughly assessed to protect people from harm and ensure their safety. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post at the time of this visit. Since our last visit the registered manager has resigned, and the general manager and care manager have been replaced with a new manager and deputy. The provider has appointed the remaining director to oversee the day to day running of the home.

The director has worked with the consultancy company and implemented many changes in staff, their deployment and changes to policies and procedures. However, many of the changes we saw at this visit were reactive to the issues reported at our last visit. For example there had been improvements for people being locked in their bedrooms for their own safety. Appropriate best interests meetings had taken place and the appropriate DoLS paperwork was in place and being monitored by staff from the local authority. However there had not been any changes to the type of bedroom door lock, and these still had the facility to be 'dead locked' (see safe section for details). That meant people were still at risk from inappropriate door locks and a staff group that failed to recognise any additional changes to fully protect people. There were further examples – see the safe section above for details.

When we spoke with the manager and asked what governance had been introduced since our last inspection in July 2015. They replied, "None." As we looked further at the safety systems in the home, we saw that some checks had been undertaken. On the day of our visit there was an electrician and engineer from a fire company checking all the detectors in the home. The manager then told us that there had been updated checks on moving and handling equipment. However these records were not available to confirm this. There had also been a follow up visit by the fire officer to ensure all the improvements required were in place. We received a separate report that these had all been completed. This meant the fire service now regarded the home had complied with file requirements to an acceptable standard.

Effective systems were still not in place to assess and monitor the quality of care. For example, some audit systems had been introduced to assess and monitor the quality of the information contained in people's care plans. However, we saw recording where information was not consistently recorded through all the documents the staff used for reporting purposes (see the safe section for details). That meant people were at risk of harm due to ineffective monitoring of all relevant care documents.

However we did not see evidence where either the manager or deputy were consistently monitoring staff practices and interactions. For example we witnessed the inappropriate way a person was spoken with by staff (see caring for details) or the unsuitable seat that a person was returned to (see safe for details). Had the situation been monitored by a member of the management team, these situations could have been resolved at the time and resulted in a more positive outcome for people. Similarly with closer scrutiny and review of documents and premises audits (see paragraph 3 in this section for details) people would have been protected from a poorly maintained environment.

We asked to look at the updated policies and procedures that had been adapted by the consultancy company and checked by the provider and manager before being implemented in the home. These were not all ready on the day. They were sent to us following the inspection. These had not been brought up to date with latest information, and some still included details of staff that had resigned from the company.

The provider had not arranged for the appointed director or staff to ensure an effective overview of the home and take action as needed. Overall we found a number of issues which had not been picked up by the providers audit systems. That meant that quality assurance was not systematically monitored and the audit systems in place were not effective or used to drive continuous improvement. This did not demonstrate a well led service.

The provider had failed to make sure quality assurance systems were in place to ensure that risk had been thoroughly assessed to protect people from harm and ensure their safety. This was a continued breach of Regulation 17 (2)a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Staff meetings were arranged and details of dates were displayed on a poster in the home. We noted one meeting had been planned following our inspection. We asked for minutes of this meeting but the manager was unable to produce these. Staff confirmed that meetings had taken place, and that minutes had been produced and circulated to the staff group. We were concerned these were not available so we could check how staff had been managed to provide effective quality care to people living in the home.

We looked at the COSHH policy and procedure, which had the name of a different home to that of the company, it was not detailed enough to assist staff to operate the policy effectively as it did not include safety information about handling chemicals or protecting themselves and others in the home.

The complaints procedure still had the address of the local CQC office which closed over 5 years ago. This meant that the document was misleading to those that attempted to use it. The updated statement of purpose still had information about the company's other homes that are being de-registered and senior staff that were no longer in post. That meant that this document was also misleading and not representative of the current company.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to make sure that risk had been thoroughly assessed to protect people from harm and ensure their safety. Regulation 12 (2) a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to provide care that was not safe, effective or that met their needs. Regulation 12 (2) a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure proper instructions were in place to enable medicines to be administered accurately and at appropriate times. Regulation 12 (2) g

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that people had been protected cross contamination or cross infection from acquired infections. Regulation 12 (2) h

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Service users were not safeguarded from abuse and improper treatment. Regulation 13 (1)
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider's legal responsibilities had not been met regarding statutory notifications that are required in accordance with the regulations. Regulation 18 (4A) and (4B)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to make sure quality assurance systems were in place to ensure that risk had been thoroughly assessed to protect people from harm and ensure their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not safeguarded from abuse and improper treatment. Regulation 13 (1)