Lifeways Community Care Limited

# Abbeymoor Neurodisability Centre

## Inspection report

Market Lane
Swalwell
Newcastle Upon Tyne
Tyne And Wear
NE16 3DZ

Tel: 01914880899

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11 January 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 3, 9 and 11 January 2018 and was unannounced. This meant staff and the provider did not know that we would be visiting.

This was the first inspection since the new provider registered to operate this service in May 2017.

Abbeymoor Neurodisability Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Abbeymoor Neurodisability Centre accommodates up to 40 people across two floors, each of which have separate adapted facilities. The service specialise in providing care to people living with degenerative neurological conditions or an acquired brain injury. At the time of this inspection, 36 people were in receipt of care from the service.

The registered manager had not been working at the service since September 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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. An acting manager had been in post since then and the provider is in the process of recruiting a new registered manager.

In September 2017, the local authority commissioners raised a number of concerns around the operation of the service and the registered manager's practices and since then the provider has had a regional staff working at the service. The provider agreed to a voluntary embargo on accepting new placements at the service. Since then they have been working to make improvements.

In November 2017 a new regional operations director started working at the service. They had instructed a quality team to complete a full and critical review of the service. This audit had identified multiple areas where improvements were needed. The provider had devised an action plan from these findings and was also using information from the local authority commissioners visits to ensure all areas for improvement were addressed. The regional operations director prioritised the order in which these issues would be addressed with high risk areas being resolved first.

When we visited, the provider had started to make improvements and had started to reduce risks by retraining staff to support people who experienced difficulties swallowing, implementing safeguarding procedures, ensuring staff safely assisted people to move, ensuring staffing levels were sufficient to meet the needs of people, completing a full fire risk assessment, and reviewing medication practices. However these actions were recently introduced so were not embedded.

Staff had been previously expected to adopt very paternalistic practices so dictated what people did and did not seek their opinions or views. People discussed their experiences of the restrictive practices the registered

manager had put in place such as refusing to allow people to see their friends. Staff had also failed to recognise when people were raising complaints, which had led to these not being raised or investigated.

We discussed with the regional operations director our concerns that staff had witnessed these practices but not made safeguarding alerts. The regional operations director assured us they were taking action to fully investigate what had occurred at the service. They subsequently sent us information from meetings they had with the staff team around what constituted abuse and how to report it.

On the first day of the inspection, we saw that a number of staff did not interact with people prior to moving their wheelchairs or taking them places. We discussed this with the regional operations director and acting manager and when we returned we found a staff meeting had been held to discuss the lack of engagement and we observed that staff were more interactive with people.

Staff did not demonstrably use techniques such as picture boards or computer assisted technology to assist people to communicate their views.

People were supported to maintain a healthy diet and to access external professionals to monitor and promote their health. However, we found that the previous registered manager had discouraged involvement with external healthcare professionals.

The acting manager was unclear as to how many people were receiving personal care only, how many people were receiving nursing care or who was funding of placement. We found that some people had been given one-to-one hours, but the staff were not sure who had this in place therefore they could not be assured that they were meeting all the contractual agreements.

The regional operations director had been reviewing staffing levels and determined that additional staff needed to be employed. They also stated that a senior carer needed to be deployed overnight.

We found the quality assurance procedures in place had lacked 'rigour', which the regional operations director had also identified. They were addressing this gap and the acting manager was being trained around how to complete meaningful assessments and analysis of the service.

The service was had been commissioned to provide re-ablement programmes but we found these were not in place. Instead for morning and afternoon refreshments set times were in place and if people wanted a drink they had to go to the dining room at these times. The regional operations director informed us that people were offered drinks at other times but agreed people needed to be supported to become more independent and undertook to look into these practices and rectify them.

Staff had been supported to access range of training over the years but had not attended refresher training recently. Staff had not received training around how to support people who may become anxious and display behaviour that challenges others. The regional operations director was aware of this gap and was sourcing courses for staff.

The care records were inaccurate and did not clearly detail people's current needs. We found that although the acting manager had been working at the service for three years he was not familiar with people's needs. However, other staff, including agency nurses could readily discuss people's needs and how these were met.

There were no assessment records, capacity assessments or 'best interests' decisions. Deprivation of Liberty

safeguards (DoLS) authorisations records were not always in place and staff were not aware of the conditions that had been imposed.

Improvements needed to be made around how medicines were managed when people went out to their relatives, how controlled drugs were monitored and how the information was recorded around the use of 'as required' medicines.

The provider ensured maintenance checks were completed for the equipment and premises. However, we found that there were many areas of the service in need of refurbishment. The regional operations director told us a full refurbishment of the service was to be completed. We found that the service was clean but some areas were malodorous and hand wash was not always available.

People spoke very positively about the activity coordinator. However, we found the service would benefit from additional activities that would support people to lead more independent lifestyles.

The cook was in the process of reviewing the menus and setting up processes such as terrines on tables so people could become more empowered when choosing what to eat.

Appropriate recruitment checks were carried out.

CQC had not been informed of significant events, as the required notifications had not been submitted. This meant we could not check that appropriate action had been taken.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, safeguarding, staffing and good governance. The service was also in breach of the Care Quality Commission (Registration) Regulations 2009 in relation to notifying us about DoLS authorisations and significant events.

The overall rating for this service is 'Inadequate' and the service is therefore 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we 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."

You can see what action we told the provider to take at the back of the full version of the report.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Staff did not recognise signs of potential abuse or report concerns to senior staff.

The provider was in the process of ensuring there were sufficient skilled and experienced staff on duty to meet people's needs. Robust recruitment procedures were in place.

Action was being taken to ensure risks were monitored and managed appropriately with the least restrictive option always considered

Action was being taken to ensure people lived in a clean and well maintained service where environmental risks were managed appropriately.

People's medicines were managed safely.

### Is the service effective?

**Inadequate**

The service was not always effective.

The care records did not contain comprehensive assessments. This meant information about people's needs was not easy to find and resulted in a volume of repetitive care plans.

People's consent was not always sought. The documentation linked to the application of the Mental Capacity Act 2005 was not in place.

Staff were being supported to gain the knowledge and skills they needed to support people who used the service.

Action was being taken to ensure people were provided with a choice of nutritious food and their on-going healthcare needs were managed.

Improvements were being planned to ensure the environment met people's needs.

## Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with respect but their independence was not promoted.

Staff knew people and used this knowledge to provide care, but at times were not speaking with people when undertaking care tasks.

Staff did not always take the time to speak with people and to engage positively with them.

People did not contribute to making decisions about their care and treatment.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not always tailored to meet the individual needs of people in receipt of care.

We saw people were encouraged and supported to take part in activities. A programme was needed to support the aim of providing a reablement programme.

The people we spoke with were aware of how to make a complaint or raise a concern. However, we found that staff had not always reported concerns, which meant these were not investigated and resolved.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager.

The quality assurance processes that had been used did not pick up issues at the service. The provider had recently ensured a critical review was completed.

The provider had been making changes at the service but these are at an early stage and therefore it was unknown if these would be sustained.

The acting manager did not know what arrangements had been made in relation to placements at the service.

People and relatives' views had previously not been sought and the provider was currently in the process of addressing this issue.

# Abbeymoor Neurodisability Centre

**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 registered 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.

An adult social care inspector completed this unannounced inspection, which took place on 3, 9 and 11 January 2018.

Before the inspection, we reviewed the information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales.

We also reviewed reports from recent local authority contract monitoring visits and attended multidisciplinary meetings held about the service.

During our inspection we spoke with nine people who used the service. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We also spoke with the acting manager, regional operations director, the project manager, two nurses, two senior carers, seven care staff, the activity coordinator, the cook, two domestic staff members and the hairdresser.

We observed the meal time experience and how staff engaged with people during activities. We looked at six people's care records, four recruitment records and staff training records, as well as records relating to the management of the service.

We looked around the service and with permission went into some people's bedrooms. We also looked in all

of the bathrooms and all of the communal areas.

Inadequate

# Is the service safe?

## Our findings

Staff had been previously expected to adopt very paternalistic practices. These practices dictated what views and opinions of the service were sought. People discussed their experiences of the restrictive practices the registered manager had put in place such as refusing to allow people to see their friends. We discussed with the regional manager our concerns that staff had witnessed these practices but not made safeguarding alerts.

Prior to the registered manager leaving the service, two members of staff from different social services departments had raised concerns about staff conduct. They highlighted that the registered manager had required staff to impose additional restrictions that had not been agreed by care managers or the Court of Protection. Also that the registered manager used derogatory language, was discriminatory, did not follow equality and diversity polices and adopted overly restrictive practices. None of the staff team had raised these matters either directly with senior staff or via whistleblowing procedures.

In addition, we noted that since the provider became registered to operate the service, we had only been notified of one incident where a safeguarding alert had been raised. We found that whilst the previous registered manager had been in post (four years) no safeguarding issues were raised. We would have expected that over the time instances would have arisen, which would have needed to be reported. Also, the single safeguarding alert referred to a person making repeated allegations about staff practices, which had been investigated but we found no other information to show that these had been reported to the local authority or to the Care Quality Commission.

The regional operations director assured us they were taking action to fully investigate what had occurred at the service. They subsequently sent us information from meetings they had with the staff team around what constituted abuse and how to report it, during which the staff had raised safeguarding matters. These had been in relation to allegations that staff had been assaulted by people who used the service which had occurred when the previous provider had operated the service. These allegations had not been reported at the time. None of the staff raised, as alerts or concerns, the overtly restrictive practices that had been adopted at the service such as preventing people from independently making drinks, seeing friends or being able to freely move around the service and outdoors.

The regional operations director and acting manager discussed the planned safeguarding training that was being organised with the whole staff team and how they had been working with staff to improve their understanding of safeguarding. However, with the staff not identifying issues that constituted abuse over at least four years, we found it would take time to be assured that staff now recognised and reported issues when they arose. It was unclear whether all safeguarding matters had been brought to the provider's attention. The regional operations director confirmed they would hold discussions with the people who used the service and staff to check that all matters had been raised and to reassure people that measures were being put in place to prevent unacceptable practices re-occurring.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people using the service had been put in place but they contained insufficient information to reduce the chances of them occurring. These risk assessments were not regularly reviewed and at times did not reflect current risks. The acting manager could not demonstrate how they were monitoring accidents and incidents to check for any trends or that they critically reviewed them to learn lessons and identify where improvements could be made.

In September 2017, during Gateshead Local Authority contract team's visit, they identified there was a lack of appropriate risk assessments and following this, the provider developed an action plan detailing how these would be addressed. The regional operations director had commenced rectifying them, risks for people with high support needs were prioritised first. We saw that this was in the early stages and risk screening had been completed for eight people, but care records had not yet changed.

We asked to see the Personal Emergency Evacuation Plans (PEEPs) and the acting manager told us that these were currently being reviewed as they needed to ensure they were accurate. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We also reviewed staff training records and found 26 out of the 33 staff had not received fire training in the last year. This meant the provider could not be assured that staff would be able to ensure people were appropriately supported in the event of a fire.

We found that although a comprehensive action plan had been developed and work was being taken to reduce identified risks, this work had been underway since October 2017; the initial work was still to be completed. The regional operations director had been in post since November 2017 and we saw that they had brought in a team of staff such as those working in the project manager and health and safety team to complete the tasks. They were optimistic that risks posed for people would be addressed in the next month.

Medicines were safely administered and securely stored, but storage arrangements needed to be improved. The first floor staff did not have access to a treatment room so the medicine trolleys were stored in the dining room. No checks of the temperatures were completed in this room so staff could not be assured that medicines were stored safely. We found that the sample of current medication record sheets (MARs) we reviewed, mirrored the stock of medication but we were aware that issues had been identified around the administration of medication. A process of two nurses signing changes to the MARs had been introduced and it had been intended that daily audits were to be completed. However, these audits had not been completed. Although the provider was looking to introduce a monthly audit from discussions with the acting manager, it was clear that at present no audit of medication was being completed. Therefore the provider could not be assured that medication was appropriately administered and a recent check by an external pharmacist found staff were making errors that were not being picked up.

Information was available about the protocols staff needed to follow when administering 'as required' medicines but this needed to include more detailed instructions about when and why to give the medication. The staff were crushing medication at times so this could be given covertly to people. However, they had not checked with the GP and pharmacist that it was safe to deal with medication in this manner. The provider was aware of these issues and had listed them on the action plan they had developed but work was yet to commence to address them.

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

The acting manager was unclear as to how many people were receiving residential care, how many people were receiving nursing care or who was the funding of placement. We found that some people had been given one-to-one hours but the staff were not sure who had this in place therefore they could not be assured that they were meeting all the contractual agreements. We also found that one person had been entitled to receive one-to-one hours so they could go out and about in the community but these had been removed because staff were not making use of them. This lack of understanding of the arrangements in place for people meant the provider could not be assured that the acting manager was ensuring the service met the contractual agreements.

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

Following our inspection, the provider's health and safety team visited the service to complete a fire safety audit. The health and safety team completed a simulated night time evacuation to determine if sufficient staff were deployed overnight.

One person told us, "The staff are always around." Another person commented, "I know staff are around to make sure I am alright."

There were two nurses, two senior carers and eight care staff on shift per day and one nurse and five care staff on shift per night. The service was heavily reliant on agency nurses and during our inspection two agency nurses were on duty each day. We found that staff were unclear as to how many staff were deployed per shift and gave us a variety of conflicting information. This meant should staff not turn up for work, those on shift would potentially not realise there was a shortfall.

The regional operations director had been reviewing staffing levels and determined that additional staff needed to be employed. They also stated that a senior carer needed to be deployed overnight. They had requested that the provider's recruitment agency took steps to recruit permanent nurses and care staff for the service.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with vulnerable children and adults.

The provider ensured maintenance checks were completed for the equipment and premises. We found that there were many areas of the service in need of refurbishment, such as flooring was worn and seals were damaged, tiles were missing in bathrooms, furniture was damaged and paintwork was scuffed. We found that the conservatory roof had been leaking for a long time and the ramps leading in to the courtyard were either too narrow to accommodate the larger wheelchairs or had insufficient turning space for people in wheelchairs to get out of the patio doors and then onto the ramp. The ramps were steep and appeared not to comply with the Disability Discrimination Act 1995 requirements around ensuring the appropriate gradient was maintained.

We found that although the domestic staff had the necessary equipment to clean the building and ensured deep cleans were regularly undertaken, seals on flooring had eroded and flooring was worn which led to difficulty removing malodours. The regional operations director told us action was being taken to ensure a complete refurbishment of the service. They had secured the necessary funding and resources to complete

the work and the first action was to refurbish the conservatory.

We found the manager checked that staff were using equipment such as hoists appropriately and when gaps in practice were identified they took immediate action. They had identified the need for more standing aides and put an order in for this equipment.

People we spoke with told us they felt the staff worked to keep them safe.

Inadequate

# Is the service effective?

## Our findings

The service was had been commissioned to provide re-ablement programmes but we found these were not in place. The service was had been commissioned to provide re-ablement programmes but we found these were not in place. Instead for morning and afternoon refreshments set times were in place and if people wanted a drink they had to go to the dining room at these times. Staff ensured people who were dependent upon staff to meet all their needs received ample fluids, but it was unclear what happened if people who were independent did not turn up for a drink. We found that staff operated in ways that reduced people's level of independence. The regional operations director undertook to look into these practices and rectify them. The regional operations director informed us that people were offered drinks at other times but agreed people needed to be supported to become more independent and undertook to look into these practices and rectify them.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff had received training in the MCA 2005 and DoLS authorisations but did not apply this to their practices. The principles of the MCA were not adhered to so staff failed to determine the range of ways they could support people to make informed choices and people were treated as lacking capacity when this had not been determined. We found no evidence that staff had completed mental capacity assessments, yet people had been prevented from having access to key codes, see their friends and make decisions about their care. Local care managers had raised concerns about staff failing to adhere to Court of Protection guidance and adopting overly restrictive practices, which was investigated and upheld.

Staff did not understand DoLS authorisations and believed the authorisation gave them the legal right to prevent people leaving the service, which is not the case. Staff also sent in DoLS applications for people who did not lack capacity. We found there was no documentation to support the capacity assessments or corresponding 'best interests' decisions. We found that DoLS authorisations were not stored in individual's files and the only document we were shown, was a matrix showing when DoLS had been authorised and expired. The acting manager and staff were unaware of conditions imposed via DoLS authorisation, the Court of Protection or actions best interests assessors had recorded on the DoLS forms.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider's care record template did not prompt staff to establish who had enacted lasting power of attorney for care and welfare or finance and if the Court of Protection had appointed anyone to act as an individual's deputy. In addition, it did not support staff through the process for referring individuals to the Court of Protection if they objected to having a DoLS authorisation.

The care records only contained a pre-admission template and therefore following people moving to the service, there was no other document for staff to use to assess their current care needs. This lack of a comprehensive assessment had led staff to using care plans as the assessment tool and meant that numerous care plans were generated. The use of care plans in this manner meant the person's priority needs were lost and staff would find it difficult to readily identify when care records were updated. This meant it was difficult to gain a clear understanding of people's presenting needs and picture of how these had impacted them. We discussed with the acting manager how the service could be enhanced by the introduction of comprehensive assessments. The regional operations director and acting manager accepted this was a gap. They told us the provider was in the process of reviewing the documentation and considering how to improve the assessment of people's needs.

We discussed with the regional operations director and project manager who informed us that the provider had assessment templates. However, they felt these should only be used for people who were to be admitted and not those already using the service. They had introduced a risk and need assessment but this provided limited information. We discussed the problems that a lack of appropriate assessment caused, for instance one person struggled to eat at a gradual pace and was therefore at risk of choking. Although the new needs and risk assessment had been completed for this individual it provided no information about their background and information that may assist staff to understand their behaviour. The acting manager was unable to tell us where the person lived before or what explanation they gave for the behaviour. This led to the care plan for managing this behaviour not dealing with how to support the person to change their eating habits. The regional operations director and project manager accepted the difficulties the lack of information presented and sent us a copy of the assessment tools they usually completed.

We saw that malnutrition universal screening tool (MUST) tools, which are used to monitor whether people's weight is within healthy ranges, were not always accurately completed or acted upon. Where people had lost weight the staff had not always ensured referrals were made to the GP and dietitians. Care records showed that staff were giving people different textured diets such as a pureed food without consulting speech and language therapists. Thus staff could not be assured that these were the correct diets for people. These issues had been raised by local visiting contract monitoring teams in September 2017 and we saw that as of early December 2017 referrals had been made. However, the staff had not yet completed a full review of all of the people's care needs so we could not be assured that everyone had been appropriately referred to external healthcare professionals.

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

Records showed staff had received training in subjects that the service deemed to be mandatory, such as moving and handling, health and safety, safeguarding and first aid and but this had not been kept up to date. Mandatory training and updates were deemed by the provider as necessary to support people safely. For instance 29 of the 33 staff refresher health and safety and safeguarding training had not been completed in over three years and this was the same for 24 staff members who received moving and handling training, 13 staff had received first aid awareness training and eight staff members had received food hygiene

training. We found that staff had not received training around working with people who display behaviours that challenge or in-depth training around working with people who live with dementia. We discussed this with the regional operations director who confirmed they had identified these gaps and were in the process of rolling out these training courses. However, it was notable that up until the concerns were raised by local commissioners and the new regional operations director had come into post, these courses had not been scheduled.

Staff had received supervisions and annual appraisals but the new regional operations director recognised that these were not consistent and staff had missed some over recent months. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Appraisals are usually carried out annually and are a review of staff's performance over the previous year.

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the previous registered manager had not encouraged staff to work with other healthcare professionals. However, since they had left the service we saw that staff were ensuring healthcare professionals were accessed in a timely fashion and were forming working relationships with local specialists in working with people who had degenerative neurological conditions and acquired brain injuries.

People told us they were happy with the service and we found staff supported them. A person said, "The staff understand me and are very good." Another person said, "I like the food." From our observations staff understood people but needed to become more adept at ensuring people were included in making choices around how their care was delivered.

People told us the meals were good, they were given a choice and alternatives were provided if they did not like what was planned. People could eat in the dining rooms or their own rooms. People were offered choices in the meal and staff knew people's personal likes and dislikes. The provider had been reviewing the catering budget and menus. They had consulted with the chef and people who used the service in regards to making improvements. The chef discussed the plans being made to improve the menus and way the food was presented. It was intended that terrines would be used so people could self-serve their meals. The provider was looking into 'smooth food tech' which is a product that allows pureed foods to be moulded into the shape of the original item.

The environment was designed to support people's privacy and dignity but the acoustics made it difficult to hear conversations in lounges, as very loud background noise was constantly present. The provider had recognised that the current design needed to be improved and were in the process of commencing a full refurbishment programme.

We found no consideration had been given to the layout of communal areas. Most people permanently used wheelchairs, with a number people needing to have large adapted wheelchairs. However, all of the communal lounges contained lots of chairs and sofas, which people did not use. We saw that staff lined up the people who used the large adapted wheelchairs across the centre of the lounges, which meant the other people in the room could not freely move around the rooms or see the television. We asked why the number of chairs and sofas in a room had not been reduced so that the lounges became more accessible spaces but staff told us this had always been the way the rooms had been set up. The acoustics within the service led to a constant and persistent loud background noise, as conversations being held in corridors could be clearly heard in the lounges and this meant people in the lounges could not hear each other speak. We found that

the provider's recent review had not identified this issue.

Requires Improvement

# Is the service caring?

## Our findings

Staff had been previously expected to adopt very paternalistic practices. This dictated what people were asked their opinions or views on. We found no evidence to show that people were involved in designing their care. On the first day of the inspection we saw that a number of care staff did not interact with people prior to moving their wheelchairs or taking them places. We discussed this with the regional operations director and acting manager and when we returned for the second day of the inspection found a staff meeting had been held to discuss the lack of engagement and we observed that staff were more interactive with people.

The provider had found that over the preceding four years, although two other providers had operated the service, the previous registered manager had expected staff to work in very restrictive and unacceptable ways with people. They and care managers had found that staff were told not to allow people to freely access the community, have access to keypad numbers within the service or to see their friends or independently access drinks. They have been taking action to deal with this but recognise that the culture within the service needed to change. The new regional operations director is currently reviewing staff practices to ensure the care being delivered is appropriate. And within this review they have been ensuring staff complete refresher training on what constitutes abuse. From recent meetings they have held with staff, we have seen that staff are starting to become more forthcoming about the poor practices that had been adopted but this is early in the review process.

People told us of their concerns about the previous registered manager's practice. One person told us, "The manager used controlling behaviour and we had feared that this may persist." We discussed these concerns with the regional operations director and they confirmed that their current investigation would be widened so they could have a complete understanding of the culture and practices within the service. They assured us that work would be completed with the people who used the service to reassure them that action would be taken to ensure these restrictive practices stopped and did not reoccur.

People we spoke with said the staff were kind. One person said, "I think they are great and do care about us." We found that staff at times did not speak with people or listen to their views. For instance staff had failed to recognise when people were raising complaints, which had led to these not being raised or investigated. People told us that the conservatory had leaked for a long time and they had told staff they were 'sick' of buckets being propped under the leaks. However, this was not reflected in the complaints and had not discussed by staff as a reason for the conservatory being refurbished. Also we found that there had been two 'relative and resident' meetings since July 2017 and these were more about information giving rather than an opportunity for people to share ideas about how they would like the service to be run.

We saw that the agency nurses and some of the staff readily communicated with people. However, we found no information to outline people's communication methods. Staff told us that advocacy services were available. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. However, we found no information to show who had access to these services.

Requires Improvement

# Is the service responsive?

## Our findings

The care records were inaccurate and did not clearly detail people's current needs. We found that staff had not always taken action to follow up changes in people's condition, for instance, staff had not made referrals to dietitians when these were needed. This issue had been raised with the provider by the local authority contracts team and they had commenced ensuring all people at high risk of malnutrition or who experienced difficulty when swallowing foods were appropriately referred. We found that although the acting manager had been working at the service for three years they were not always familiar with people's needs. This meant they could not speedily assist the provider to identify, which people would require referral and only until a comprehensive assessment of people's needs was completed would this be achievable. We did find that other staff, including agency nurses could readily discuss people's needs and how these were met.

We found that the provider was in the process of replacing all of the previous provider's care documentation with their own. This documentation was being adapted to meet the requirements of a nursing service as the provider operated supported living facilities and this is one of the first nursing homes they had purchased. They had introduced one page profiles for care staff to complete but these did not address nursing needs. The quality manager was in the process of producing new care records for one person but needed to ensure these were specifically outlined how staff were to work with people. New care records needed to be completed for all 37 people who used the service.

Although procedures were in place to investigate and respond to complaints none had been recorded as raised in the complaints file. We found that the staff had not been bringing people's concerns to the attention of the manager. We heard how the previous registered manager had undermined staff and made them reluctant to raise any concerns or issues. They had not equipped the now acting manager with the skills to investigate complaints and take action to rectify concerns.

We found that 'relatives and residents' meetings were held but only a few people attended. We found that at present staff did not routinely seek people's views and we found they had not considered how assistive technology could be used to support people to communicate. The regional operations director discussed the range of ways the provider was encouraging people to share any concerns and views about the service.

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

From our review of 'relative and residents' meeting minutes and discussions with people, we found that they were very complimentary about the activities coordinator. The activity coordinator had worked at the service for many years and was in the process of reviewing the range of activities on offer. Currently the activities were designed around trips out and general activities within the service but these did not support people to develop their independent living skills. The regional operations director had been working with them to determine how the activities could be enhanced. They said, "I have recently being taking everyone to the panto and have taken three people to each show."

Requires Improvement

# Is the service well-led?

## Our findings

At the time of our visit, the acting manager had been in post for three months and the registered manager had left the service.

We found the quality assurance procedures in place had lacked 'rigour', which the regional operations director had also identified. They were addressing this gap and the acting manager was being trained around how to complete meaningful assessments and analysis of the service.

The quality assurance systems being used had not identified that the culture within the service had been extremely restrictive, the way risks for people were managed needed to be improved, staff were not adhering to the principles of the Mental Capacity Act 2005, staff training needed to be updated and the care records were inaccurate. This only became known following complaints being raised by care managers and the local authority commissioning team quality audit. Since this was raised with the new provider, they have been taking action to improve the service but these improvement actions were at an early stage.

The current quality assurance processes had not identified that the service was not providing the re-ablement programmes. We found that staff followed very regimented practices; for instance no one was allowed to make their own drinks and if people wanted a drink they had to go to the dining room at set times. The lack of a comprehensive assessment was hindering staff ability to ensure risks were appropriately managed and people's needs were clearly understood.

Although some auditing and analysis was carried out, this was not always effective. For instance, the provider determined that daily medicine audits needed to be completed and then found these were not, so reviewed the process and decided monthly audits of medication could be completed. Yet at a recent pharmacist visit, it was found that the system had not identified that a nurse had accidentally discontinued an individual's medication. The previous registered manager had not been completing the audits but the provider's checks had not identified these issues. The regional operations director and provider were aware of the deficits in the system and had brought in their quality team to complete a full a critical review of the service then assist staff to make the necessary improvements to the way reviews were completed.

The acting manager recognised they needed to learn additional managerial skills and the provider was sourcing training for them. We found that they needed to review the service to establish what contractual arrangements were in place for each person and ensure these were met. They were at the early stages of developing the skills they needed to oversee the operation of a care service.

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

Although we made the acting manager aware that we needed to be notified of events such as when the outcomes of DoLS authorisations were known. To date, we have not received any notifications in relation to DoLS authorisation but are aware that 18 people are subject to DoLS authorisations. We will be dealing with

this matter outside of the inspection process.

This is a breach regulation 18 (Notifications of other incidents) of the Care Quality Commission (Registration) Regulations

The new regional operations director had been in post for a month and had completed a full review of the service and started to make changes. They assured us that the provider was committed to ensuring the service operated in line with regulatory requirements and we found that a whole range of resources were being made available to improve the environment, train staff, alter staff practices, bring in new documentation and improve governance at the service. Thus the provider's quality team were working at the service several times each week, the regional operations director was at the service most days of each week and this team had been given authority to make any purchases they needed.

Staff told us "I find that the new owners are interested in making sure the home runs well and it is so much nicer here than when [name of previous registered manager] was here." Staff told us that the acting manager and nurses were really supportive and always at hand to help.

The acting manager told us they were well supported by the provider and regional operations director. Staff and the acting manager told us the provider had been receptive to their suggestions.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not ensured the service was delivering safe and effective care.<br><br>Regulation 12 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not ensured that staff protected people from abuse and improper treatment.<br><br>Regulation 13(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured that the systems and processes that were in place to assess and monitor the quality of the service were effective.<br><br>Regulation 17 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received the support, training, professional development, supervision and |

appraisal needed to enable them to carry out the duties they are employed to perform.

Regulation 18 (2)