Agemco Ltd

Capricorn Cottage

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 5 and 7 September 2016 and was unannounced.

The home is registered to provide care for up to 34 people who are living with autism or learning difficulties. The home is a purpose built care home on a single level. There are kitchen and laundry facilities available for people who can be supported to be independent. There were 24 people living at the home on the days we inspected.

There should be a registered manager for the home. The last registered manager had stopped working at the home in March 2016. At our inspection we found there was a new manager in post. They had started working at the home on 15 August 2016. They confirmed that they were in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

When we inspected on 25 November 2015 we found that the provider did not ensure the care and treatment people received was appropriate, met their needs and reflected their preferences. Risk to people while receiving care were not always identified and plans to reduce risks were not effective and did not keep people safe. Furthermore, the provider had not followed the requirements of the Mental Capacity Act 2005 to ensure people's rights were protected. After the last inspection we asked the provider to take action to make improvements to the concerns we had identified.

At this inspection we found that the provider had not made the improvements needed and had failed to ensure that previous improvements had been sustained. We found that there were now seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. You can see what action we have taken at the back of the full version of this report.

The provider had not followed the requirements in the Mental Capacity Act 2005 (MCA) to ensure people's rights were protected. Mental Capacity assessments had not been carried out to show what decisions people were able to make for themselves and best interest decisions had not been made when restrictions had been placed on people.

Staff had received training in keeping people safe from abuse. However they had not been able to recognise abuse within the home. In addition they had physically restrained one person without having a care plan in place and had not recognised that this could be classified as abuse. Furthermore staff had also administered medicines without the guidance of a care plan to chemically restrain the person.

There were not enough skilled and experienced staff available to meet people's needs and adequate cover

was not provided when staff were on leave or were sick. Staff had received training but good practice had not been reflected in the care they provided people. Additionally, shortfalls in care were not identified when staff received their supervisions. Although some staff were individually caring they lacked time and support to build caring relationships. At times this led to staff being adversarial and disrespectful with people.

Risks around people's abilities to maintain a healthy weight were not managed and this left some people at risk of malnutrition and other at risk of poor health through obesity. In addition, mealtimes were not a pleasant experience for people and were not individualised to meet people's needs.

Medicines were administered safely but some systems put in place to manage medicines safely were not being followed. Other risks to people were not fully identified and the care put in place did not fully protect people from the effects of the inadequate care. Care was not always planned and delivered in a way which met people's individual needs and people were not supported to access their care plans or to be involved with planning their care. People were supported to access advice and support from healthcare professionals but staff did not always complete requested monitoring.

Staff did not support people's independence and made it harder for them to complete tasks they were competent to undertake. Equipment to support people's independence was not always available.

The provider had failed to develop a stable effective management for the home and ineffective handovers when managers changed had led to improvements that had been made not being sustained and no improvements where further action had been identified as being needed. Staff morale was low and they were failing to adequately implement the changes the manager had introduced. Audits in place to monitor the quality of care people received were not being effectively completed. The computerised care plans were not completed and were not always available for staff.

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.

Staffing absences for sickness and annual leave were not effectively.

Staff had received training in abuse, but did not always recognise abuse. People were not protected from unauthorised restraint.

Risks to people were not fully identified and the plans put in place to protect people and reduce their risk levels were not effective.

People's medicines were administered safely but a lack of guidance around medicines prescribed to be taken as requires meant people may not receive consistent support from staff.

Is the service effective?

Requires Improvement

The service was not effective.

Where people may not be able to make decisions for themselves staff had made decisions on their behalf without assessing their capacity or including relevant people in a best interest decision.

Staff had received training and support. However, training had not been delivered in a way that staff understood and therefore care was not supported by the latest best practice.

Mealtimes were not a pleasant experience for people and people were not supported to personalise their meals to their own taste. People were not always supported to access hot and cold drinks whenever they wanted one.

Is the service caring?

Inadequate

The service was not caring.

Individually some staff were kind and caring. However, they were not supported by systems or the caring environment to build positive relationships with people. At times this created an argumentative environment.

At times care was institutionalised and the care provided for people was focused on the task to be completed instead of people's individual needs.

People were not always treated with dignity and their independence to care for themselves as much as possible was not supported.

Is the service responsive?

Inadequate

The service was not responsive.

People were not supported to access their care plans or to input into plans around how they wanted their care delivered. A lack of person centred care plans meant that care was not meeting people's individual needs.

Information passed between shifts did not always support people to receive the most appropriate care to meet their needs.

Activities had not been tailored to meet people's interests and so people failed to enthusiastically engage with the activities provided.

The manager was supporting people to raise any concerns with them, however lack of access to complaints records meant that we were not able to verify they had been handled in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured there was consistent management of the home and important information had been lost when managers left.

The provider was not supporting the manager to have the time to make improvements before focusing their attention on other tasks.

There had been no recent attempt to gather the views of people using the home and people were not supported to engage with the development of the care they received.

The audits in place to monitor the quality of the care and the environment had not been completed effectively and where issues had been identified there was no record of what action had been taken.

Capricorn Cottage

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 5 and 7 September 2016 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home.

During the inspection we spoke with five people who lived at the home and spent time observing care. We spoke with a senior care worker, three care worker, the administrator and the manager.

We looked at six care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Inadequate

Is the service safe?

Our findings

At our inspection on 25 November 2015 we found risks to people were not fully identified and care was not always planned to keep people safe. In addition, generic risk assessments did not support staff to provide person centred care. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Following our inspection the provider wrote to us and told us they would review people's risk assessments to ensure all risks were covered and reduced to the lowest practical level. They assured us that when new risks were identified the care plan would be updated with the information needed to keep people safe.

At this inspection the care plans and risk assessments had been transferred onto the new electronic care plan system. We saw there were some risk assessments in place. However, they were not always effective. For example, a risk assessment for a person who needed to lose some weight showed that nutritional information should be offered to them, along with choices of food. They also needed support and encouragement to take frequent walks and to attend the dietician's appointment. We saw that the care plans recorded that this had taken their level of risk for eating inappropriately to a low level. This would suggest that the plans in place were enough to manage the risk for the person and that no further action needed to be taken. However, the available records for this person showed that they had increased in weight by nearly half a stone from February 2016 to May 2016. This impacted on the person's health as their legs were swollen and weeping. We discussed this with a senior member of staff who explained that the person was accessing the community with support from the activity coordinators and would take the opportunity to purchase sweets and crisps. This was not identified in their risk assessment.

In addition, we saw assessments to help people at risk of malnourishment were ineffective. Since starting at the home three weeks prior to our inspection the manager had identified that one person was underweight and that no action had been taken to support the person. Their body mass index (BMI) was recorded at 14. A healthy BMI is in the range of 18 to 25. There was no clear record of regular weights. The manager reported that at some stage the person had been given some fortified drinks.
However, these had not been prescribed by the GP and once they had run out no action had been taken to refer the person to a GP for support. Since starting at the home the manager had ensured the person had been referred to a healthcare professional for advice and support.

We saw another person had last had their weight recorded in their care plan in February 2016 when their BMI was 17. Staff showed us sheets of paper with people's weights recorded however these were not properly dated and so it was not possible to accurately track the person's weight. We saw in February 2016 when the person's BMI was 17 no risk assessment was completed and no care plan was put in place to support the person to maintain a healthy weight. Following our inspection the manager told us they have now referred this person to a health care professional for advice.

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

Staff told us that they had received training in safeguarding people from abuse and that they had read the companies abuse policy. Staff also told us they were confident to raise concerns both within the organisation and to external agencies such as the local authority. The safeguarding number for the local authority was available in in the staff office. However, we saw that staff were unable to recognise that some of the care they provided to people was unsafe and could be harmful to people. For example, we discussed with a senior member of staff what they would do if they saw one person hit another. While they were able to describe how they would support the people to be calm and ensure they were not hurt, they did not recognise this as abuse which would need reporting.

The manager told us and an incident report showed that one person had become more distressed after having their medicine changed. They had increasingly shown their distress in a physical manner by throwing items such as cups and hitting out at people. Records showed during one incident on 28 August 2016 while the person was distressed, staff chose to physically restrain them and lower them to the floor. There was no care plan in place to show that this person had agreed to the restraint or that a best interest decision to restrain the person had been made. The restraint was not part of a planned process of care and no information was available to staff oh how they could restrain the person safely.

Following the change in medicine, staff had contacted the consultant psychiatrist who advised that the person could be given a different medicine to help them manage their emotions as required up to a maximum of four times a day. This was confirmed in an email and the person's care plan was update to reflect this. However, there was no guidance available in the person's care plan to support staff to administer the medicine as required. We saw on a number of occasions that the medicine had been given when the person was not distressed. For example, we saw one day it had been given three times and their daily monitoring form consistently recorded that they had been quiet. The over medication in effect chemically restrained the person and we saw that it had a negative effect on their abilities. Their monitoring form recorded that the person fell asleep in their chair and was very sleepy at tea time and was unsteady when walking.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safeguarding service users from abuse and improper treatment.

The manager told us that staffing levels had not been set using a tool and were historical. However, they told us they were in the process of completing an assessment of people's needs and would use this in future to set staffing levels. During our inspection we saw that there were not always enough staff available to meet people's needs and appropriate cover had not been arranged when staff were on leave or off sick.

During the first day of our inspection we saw that there was no senior member of staff on the afternoon shift. There was a member of staff who was trained to give medicines on duty until 6pm and a senior member of staff had agreed go to the home at 8pm to give the night time medicines out. This meant until the night staff started work there were times when people would have been unable to access their medicine if they needed it. In addition, an activity coordinator was on leave and their shifts had not been covered. This meant that people were offered less choice about the activities they could undertake.

We saw examples of inadequate staffing levels throughout the inspection. An example of this was when one person began coughing quite violently while eating their meal. After a short delay two members of staff came and patted the person on the back. They did not hurry to support the person and had to leave other people who they were supporting to eat as there was no free member of staff in the dining room. We also saw a person was doing a puzzle but there were not enough counters of the right colour for them to complete the task. They needed some support to finish their task but no one was available to help them

with the activity.

We looked at the records for two members of staff who had started working at the home since our last inspection. We saw that one person had not completed any information in the employment history section and had not included any information in their personal statement. There was no record that the provider had investigated their previous employment history during the interview process. While there were two references on their file the provider could not be confident that they had received a reference from their most recent employer. The second member of staff had fully completed their application form and had had two references. Both members of staff had a disclosure and baring check completed to show that they were safe to work with people living at the home. We saw the provider had gathered evidence of people's prior learning.

We observed some of the medicine round and saw that it was completed in a methodical manner which reduced the risk of errors, For example, the member of staff only administered medicines to one person at a time and ensured that the person took the medicine before completing the medicine administration record. There was no one at the home who currently needed to take medicine which required more secure storage arrangements. Medicine administration records had been fully completed. However, we did see that bottles of medicines had not been dated to show when opened. As some medicines have a limited life span once opened there was no way of ensuring the medicine was still effective. In addition, there was no information in the records of people's individual needs around the administration of records. For example, a senior member of staff told us how one person often preferred to take their medicine with yoghurt instead of a drink of water. This was not recorded in their care plan.

Requires Improvement

Is the service effective?

Our findings

When we inspected on 25 November 2015 we found the provider had not fulfilled their responsibilities in ensuring people's rights were protected when they were unable to make decisions for themselves. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

The provider wrote to us and told us they would ensure that Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was completed by all staff by the end of March 2016. In addition, they said that capacity assessments would be completed for all people living at the home and that the DoLS applications had been submitted in November 2015 for all people living at the home who lacked capacity.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the manager and staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that applications for authorisations for DoLS had been completed by the previous manager and had been sent to the local DoLS authority. However, they had been completed for some people who had capacity. This showed that the person who completed the applications had not fully understood their responsibilities under the MCA.

Staff had received training for the MCA and had an awareness of the mental capacity act. For example, they knew that they had to assume that people had capacity and that at times some people needed time to think before they could give a response to a question. However, this understanding of the people's rights to make decisions was not reflected in the care provided to people. An example of this was how people's moneys were managed. One person did not have any access to their money, staff told us this was because they did not have the capacity to understand their money and how much they were spending. There was no mental capacity assessment to show that they did lack capacity to manage their finances. Other people had limited access to their money. For example, several people were given a set amount of money each day to go to the shop. However, there was no mental capacity assessment to show the person was unable to manage larger amounts of money and no recording of a best interest decision to show how the daily amount had been arrived at.

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

We saw that mealtimes were not a pleasant experience for people. Each meal had exactly the same food with the gravy already poured over the meal. People were not given the ability to personalise their meals to what they wanted to eat that day. There was a choice of food at mealtimes and some people were offered a choice but other people were not supported to make this choice. For example, a member of staff offered a choice of two puddings to one person, once they had made their choice the other pudding was placed in front of a person without offering them a choice. When all pudding had been served out the member of staff saw that there were no spoons on the trolley and went back to the kitchen to fetch them. As one of the puddings was an ice cream it had started to melt by the time the person was able to eat it.

We saw that some people had equipment to help them eat independently. However, supportive equipment had not been made available to all people who needed it and food was not tailored to people's abilities. For example, a member of staff was helping a person who was feeding themselves with a spoon. The person was eating quite well but had some difficulty keeping food on their plate. The manager approached and commented to the member of staff that the person would be better with a plate guard. The member of staff did not respond to this and the person carried on eating.

Snacks offered to people were not always appropriate for their needs and the same snack was offered to everyone instead of being tailored to meet their nutritional needs. An example of this was supper time when everyone was offered either biscuits or crisps. This did not take into account some people's risks assessments which showed they needed support to lose weight.

People were not always supported to have a drink when they asked for one. The manager had identified that people could help themselves to cold drinks during the day. However, we saw that staff were not supportive of this and had neglected to put them out on the side. The staff meeting minutes showed that this was not a one off issue as they noted that a person was told that they would have to wait for lunch for a drink. People were also not able to access a hot drink when they wanted one. One person told us, "You can ask if you want a cup of tea and they say it's not time."

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 meeting nutritional and hydration needs.

One person at the home who was diabetic had been struggling to manage their blood sugars. A senior member of staff had liaised with the NHS diabetic nurse to understand the person's needs. This allowed them to provide better support to the person regarding their diet. We saw that this had helped the person to keep their blood sugars controlled which meant they were less likely to be ill due to their diabetes.

At our inspection on 25 November 2015 we found that training was not always effective. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to keep people safe.

At this inspection we found staff were not supported with effective training. Staff told us and records showed that some training had been ongoing. In addition, new staff had completed an induction which included training in subjects such as infection control and safeguarding people from abuse. They had also shadowed a more experienced member of staff, completed the care certificate and were supported to undertake nationally recognised qualifications in care. However, despite this training we saw that providing good safe care was not embedded in to the everyday care people received.

The manager was concerned as they felt that the training had not been delivered in a way that was fully accessible to staff. This meant that staff had not fully understood their training and how it should be reflected in the way they supported people. We saw despite training around challenging behaviour had left staff without the skills they needed when a person living at the home started become more distressed after a change in their medicines. This led to staff using unauthorised physical restrain to keep the person and others living at the home safe. However, they had not understood the impact and risks this could have for the person. In addition, the same person had been overmedicated by staff as they had not been trained and so did not have the knowledge of other methods which may have helped manage the person's distressed reactions.

We found that at times the staff did not show they had the skills and understanding needed to care for people living at the home and did not consider the impact their actions had on the people they cared for. We saw this was evidenced in the minutes of staff meetings dated 15 and 30 August 2016. The minutes showed that at times staff did not take responsibility for providing safe effective care regardless of skills or training. For example, one comment recorded was, "If some staff see a wet bed, they will just throw a cover over it, this is left to other staff to clean up after." Another comment noted that incontinence pads were left on the floor. The minutes also showed that staff did not always support people to be independent and that one person enjoyed making a hot drink but that staff did not have time to help them. This caused the person to be upset and display distressed reactions to get the attention they needed from staff.

Staff told us that they received regular supervisions from a senior member of staff on a three monthly basis to discuss their performance, training needs and any issues they had. However, despite the training and supervision their continued to be poor delivery of care as highlighted throughout this report.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

Individual care plans included information needed to support people's day-to-day health needs. However, guidance and advice from healthcare professionals was recorded in people's daily notes and was not immediately available to staff. This meant when care was reviewed important information about changes to people's needs could be lost amongst all the other information recorded about people's daily lives. We saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

However, we saw that senior members of staff had not always acted on requests from healthcare professionals to monitor people's health. For example, we saw that there was a request to monitor the blood pressure of one person on a weekly basis. This care had not been completed and there was no plan in place to ensure that the person's blood pressure was taken on a regular basis as requested. Records showed that the information had not been included in handover information when shifts changed and staff were not fully aware of the person's needs.

Inadequate

Is the service caring?

Our findings

When we inspected on 14 January 2015 we found people were not treated with respect. We told the provider that they needed to improve and on our inspection on 25 November 2015 we found that some improvements had been made but noted that there was a lack of care planning to support positive communication with people. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to keep people safe.

However, at this inspection we saw that the improvements had not been sustained and that there had been no improvement in care planning to support people's communication needs. People's communication needs were not recorded in their care plans and there were no tools available to health and social care professionals to support them to engage with people. This was important as people had individual communication styles dependant on their abilities and without the knowledge of their abilities other people may misunderstand what people were trying to tell them.

Staff we spoke with were kind and caring. An example of this was how a senior member of staff became upset when we spoke about a person's needs and how they were not being met. They told us how worried they were for the person as they were not complying with their care needs.

However, given the poor quality of care and the lack of support people had to be occupied and entertained staff found it difficult to promote this caring nature and build positive relationship with people. This was because they were dealing with the distressed reactions. An example of this came from a senior member of staff who told us, "Sometimes some of the residents can goad staff into retaliation and that is when I would step in and support them." This created an atmosphere in the home and lead to incidents such as we saw recorded in the staff meeting minutes of 30 August 2016 where the manager raised concerns about inappropriate language being used to describe people living at the home.

People living at the home told us some of the staff were kind to them but that others shout at them. One person told us, "[Member of staff] shouts and another had a go at me last night. They said you have to stay in bed and with nothing to eat ever." We asked the person if staff were ever unkind and they said, "Some of them are grumpy, I just ignore them." We saw little positive interaction between staff and people living at the home. Staff were focused on the task they were completing and did not engage people in conversation. People also told us that they were not allowed to ring the bell and that if they did ring then staff would often not respond. They gave a list of names of staff who did not respond to the bell when the person rang for support. Another person explained that they preferred one member of staff over others. A member of staff told us that the person preferred the staff who helped them to do things rather than do it for them. This showed that there was an inconsistent approach to care from staff.

At our inspection on 25 November 2015 we had noted that the mealtime experience for people was institutionalised. Lunch was served at 12 pm, at 2.30pm a drinks trolley came round offering tea or coffee and tea was served at 4pm. Everyone had plastic cups and plates. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to help people have a more

enjoyable experience.

At this inspection we saw that mealtimes were still institutionalised and still served at the same times. All the people living at the home were served their hot drinks in plastic mugs and had their afternoon tea on plastic plates. While there many have been an acceptable reason why one or two people needed to have plastic crockery, most people would have been safe with ceramic crockery. This showed that care at the home had been institutionalised to a one size fits all regime.

We saw in one area of the home, where people chose to spend time and to eat their meals, there was a notice board which displayed the daily menu in picture format. However, we saw it did not reflect the meals on offer that day. A member of staff told us that they had never changed it and would not know where all the different pictures were. We saw that staff did not anticipate people's needs. For example, one person asked for more of their main meal at lunch time and was brought more food. However, staff did not offer other people second helping and some of the people were not able to ask for more food, but could have made a choice when offered another helping.

People's care plans had been transferred to an electronic format. People were not supported to access the computer and they were therefore unable to access their care plans independently. The computer system used was unable to present the information in a format that people would be able to access easily. In addition there had been no discussion with people around their care needs to involve them with planning their care. For example, where people needed to lose weight there had been no meeting with the person to sit down and discuss a weekly menu plan with them which included, how meals could be altered to have less calories but still be acceptable to the person. In addition, we saw that one person who was at risk of being unable to maintain a healthy weight was regularly refusing to be weighted. There had been no conversation with the person to see why they were refusing to have their weight monitored and if any action could be taken to help them feel comfortable to have their weight recorded to help them stay healthy.

There were a number of areas called "pods" in different parts of the home and it was not clear what each area should be called. One area was constantly called 'the dementia unit'. We were told that this is an historical name and that there was no one with dementia living at the home. This name was not respectful for the people who chose to spend time in this area.

People were not supported to manage their dignity. At our inspection on 25 November 2015 we had noted that we saw one person who had spilt a cup of tea down their front. We raised this with a member of staff who explained that the person, who was in their nineties, often spilt their tea and would be changed before lunch. There was no information in their person's care plan to see if support was needed for them while drinking or if a different drinking beaker would be more appropriate for them. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to help the person maintain their dignity. While we saw that the person was clean and dry during our inspection, a commissioner of care reported to us that they had visited the home on 15 September 2016 and had seen that the person had spilt their tea over themselves and was wet from their neck to their waist. This showed that consistent action had not been taken to help this person.

People were not supported to gain or improve their skills for independent living. Some people living at the home were capable of being independent with some aspects of daily living with support. For example, by making some meals and doing their own washing. However, we saw that people were not supported to engage in these activities. People were not supported to do their own laundry instead it was done by the staff for everyone in the home with people's washing mixed together. This was not a person centred approach.

In addition, all the cupboards in the independent kitchen were locked so people were unable to access their contents independently. One person has been assessed as able to make a drink independently. The manager had arranged for them to have access to a kettle and provisions. However, on the first day of our inspection we saw that the person did not have any milk available and needed to go to the main kitchen each time they made a drink. They told us this was because they had spilt some milk and staff had said they could no longer have it. The manager spoke with staff and arranged for the milk to be available.

People were not supported to access their money whenever they needed it. People's money was stored in the administrator's office. This meant that outside of office hours people were unable to access their money unless it had been planned in advance. This meant if people made last minute plans they were unable to access their own money to take out with them.

At times information staff had recorded did not show that they respected the people they were providing care for. For example, one person was meant to be encouraged to take regular walks. Records showed one senior member of staff had completed the evening monitoring form and had written, "Sat on bottom." This was not respectful as the person needed guidance and support not criticism.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 dignity and respect.

We saw that the new manager had provided one person with the key to their room. The person was private and preferred to be in quieter areas and had told the manager that they were fed up with people walking into their room uninvited. The person was very proud and showed us their key and told us that they were happy with the new arrangement as it protected their privacy.

Inadequate

Is the service responsive?

Our findings

At our inspection on 25 November 2015 we found that there was a continued breach of regulation 9 and that people were not receiving appropriate care. Although care plans had been updated since our inspection earlier in the year they did not fully reflected the care people needed.

Following the inspection the provider sent us an action plan and told us they would review the care plans to ensure people's individual needs were recorded. They also told us that residents' meetings would take place monthly to ensure that choices were listened to and actioned.

At this inspection we found that the care plans had been transferred to the computer system. However, they had not been reviewed or updated to ensure that they fully reflected people's needs. For example, where people needed their care individualised to prevent them becoming distressed there was not always a care plan in place to help staff deal with the situation in a consistent manner.

With the manager's permission we pushed the call bell and it took four minutes for staff to respond. Staff told us that they took this long as the call bell panel only had a room number and they did not know which room the number related to. A person who lives at the home was with us when we pushed the bell and they became anxious and said, "You better cancel it." When this person saw staff were coming down the corridor their anxiety increased over the staff's reaction to the bell and they removed themselves from the room. This showed the person did not relate using the bell with a positive response from staff.

At our inspection on 25 November 2015 we found care plans did not contain information to support members of staff to administer medicines prescribed to be taken as required. For example, medicines to calm people down when they got distressed. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to keep people safe. At this inspection we saw that there were some protocols in place to support staff to administer medicines which had been prescribed to people to be taken as required. However, for some people these protocols did not support staff to consistently assess when the person needed the medicine. For example, we saw one person was prescribed a medicine to help them remain calm instead of being distressed. The protocol only recorded that the medicine was prescribed for behaviour. There was no further information to guide staff as to when medicine should be used and when distraction techniques should be used. This meant we could not be sure that staff were not using medicines as the initial solution to help people remain calm instead of trying other ways to engage and distract them.

At our last inspection in on 25 November 2015 we noted that one person who was anxious was not supported to manage their anxieties and they raised concerns with us about the care and support they received not meeting their needs. We included this information in our report so that the provider was aware that this person needed further support. At this inspection the person was still anxious and would look for support and reassurance from staff but could not be sure that it would be forthcoming. There was clear guidance in the person's care plans on how staff could help them manage their anxiety but this was not being followed. This lack of consistent care meant that the person's anxiety was not improving.

We saw that there were systems in place to ensure that important information was recorded so that staff coming on shift were able to identify changes in people's needs and if anyone needed extra monitoring to ensure their needs were met. However, we saw that information was not always handed over. For example, one person who needed help and support to lose weight had information recorded in their care plan that they needed regular encouragement to walk. We saw that when they had not wanted to walk in the morning this information was not included in the handover. This meant that staff on shift in the afternoon did not have their awareness raised that this person needed extra support in the afternoon to encourage them to move around the home.

This was a continuing breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person centred care.

Earlier in the year there had been an incident where a person had an epileptic seizure and had to be taken to hospital. We spoke to a senior member of staff about the incident and other people living at the home who had epilepsy. The senior member of staff was able to speak knowledgeably about the different types of seizure people had and when it would be necessary to call for an ambulance. We saw each person had an epilepsy risk assessment in place.

When we inspected on 25 November 2015 we found that the provider had increased the activities provided and there were three different activities planned each weekday morning and afternoon, with people given the choice of which activity they wanted to attend. We noted and staff told us that the improvements in activities had led to a calmer atmosphere and there had been a reduction in the number of distressed reactions people displayed.

However, at this inspection we found that these improvements had not been sustained and that that there were not many people engaged with activities. For example, on the first day of our inspection two people had been supported to go swimming and a few more were taking part in craft activities and doing jigsaws. A member of staff told us that one of the activity coordinators was on leave and that this had impacted on the amount of activities provided. However, they added, "Half of them [the people living at the home] don't want to do things." We saw a number of people had chosen not to engage with the activities provided and spent time walking around the home. This showed that activities had not been tailored to people's needs or used to help them to remain calm, settled and engaged. There was also no activities planned in the evenings and weekends.

There was a copy of the complaints leaflet and policy in the reception area. However, they were not available in different formats to ensure all the people living at the home could access the information. The administrator told us that there had been two complaints since our last inspection but they were unable to show us the information as they could not find the file. We were therefore unable to verify if this was correct and if complaints had been dealt with in line with the provider's policies.

The manager told us that since they had been at the home they had encouraged people to raise their concerns directly with them. We saw that the manager had an open door policy and that people were happy to visit the manager and tell them about their worries.

Inadequate

Is the service well-led?

Our findings

When we inspected on 14 January 2015 we found that the provider did not have an effective system to assess monitor and improve the quality and safety of care provided or to identify, assess and manage risks to the health, welfare and safety of people living at the home. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance. At our inspection on 25 November 2015 we found the provider had made improvements to the systems to monitor care. While there was still more improvements required we felt that at that time the provider was meeting the requirements of Regulation 17.

At this inspection we found that the improvements identified in November 2015 had not been sustained and that once again systems were not effectively monitoring the quality of care people received or identifying where developments were needed. This was because the provider had failed to establish and maintain an effective management team.

We found that since our inspection in November 2015 there had been two changes of manager and deputy manager. There was currently no registered manager for the home. The original manager had de-registered with the Care Quality Commission and the second manager had not had time for their application to be processed before resigning. The manager at this inspection had been in post three weeks and was completing their application to become registered.

We found that the provider had not ensured that there were effective handovers of information between the managers and so improvements one manager made had not been passed onto the next one. An example of this was that at our inspection in November 2015 we saw that the manager had started to use a tool to help them identify the number of staff needed to meet people's needs. However, at this inspection the new manager told us that there was no tool in place and that they were looking to identify which was the most appropriate one to use.

We also found that the ineffective handovers meant that despite submitting action plans following our last inspection the provider had not ensured that the plans to improve the care people received had been implemented. This meant that people living at the home had been receiving a poor quality of care for a prolonged period of time.

The manager was getting to know people living at the home and to gather their feedback on the care they received. They had an open door policy so that people living at the home, staff and visitors could all access them to raise issues. This also allowed the manager to be aware of what was going on in the home and if people living at the home or staff were in need of extra support. In addition, there was a residents' and relatives' meeting planned for 20 October 2016. The previous meeting had been held on 7th May 2016. The manager planned to have meetings every three months going forwards. There had been no recent survey to gather the views of people living at the home and their relatives. However, the administrator told us that the manager wanted to give people time to get to know them before gathering their views.

The new manager had held two staff meetings since they had been in post. These showed that the staff had a low morale and that they were not working together as a team. The minutes also showed there was a culture in the home around not challenging poor care delivery. Minutes from a recent staff meeting showed staff were reluctant to raise performance issues with the manager as they felt other staff would identify who had raised they concern and they would be criticised by colleagues and nothing would change. This allowed poor care to continue to be delivered despite ongoing training. Furthermore, we saw that staff were undermining the changes the manager was implementing and that senior staff were not always supporting the changes made by the manager. The manager was completing individual supervisions with all staff to enable them to raise any concerns or issues they could not raise in front of colleagues.

The provider had invested in a new computerised record management system and had provided the staff with laptop computers and tablets to access and record data onto the system. However, the internet for the home was not stable and so access to the information was unreliable. One member of staff told us, "The internet is not good so the system shuts down for hours at a time." Another member of staff said, "It's a problem when the internet goes down which is a daily occurrence." People could therefore not be assured that staff and visiting health professionals would have access to their care plans when needed.

In addition, staff had not consistently used the system to record information. An example of this was people's weights which had been recorded on loose sheets of paper, some of which were not dated. Therefore it was impossible to know if people were losing or gaining weight and needed further support. Another example was that information about visits from healthcare professionals was recorded in the daily notes and was difficult to find. There was a separate section to record this information so that it could be easily accessed, but this has not been used.

There had been some audits completed, for example, we saw care audits had been completed for four people in July 2016. Kitchen audits, an infection control audit, a health and safety audit and a medicines audit had also been completed. However, we saw that these audits were ineffective and had not identified the issues we found during our inspection. Where some issues had been identified in the medicines audit no recorded action had been taken to stop the same issue reoccurring in the future. This showed that the audits were not effectively implemented to drive improvements to the quality of care people received.

This was a repeated breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.

The manager told us that following our previous inspection and some visits by the local authority the provider had employed a consultant to look at the concerns around the home. The manager had reviewed the outcomes of all the reports and had identified areas in which they wanted the home to improve and reflect the current best practice guidance for learning disabilities. The manager was also in the process of appointing a new deputy manager to provide clear direction and leadership for staff while providing care.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect and did not have their independence supported. Regulation 10 (1) and 10 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people were not assessed and reasonably practicable action was not taken to mitigate risks. Regulation 12 (2) (a) and (b).

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 People were not protected from abuse and improper treatment as the systems in place

were ineffective. People were not protected from unnecessary restraint.

Regulation 13 (2) and13 (4)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not supported to access food and hydration suitable to their needs. Regulation 14 (4)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not assess and monitor the quality of care being provided and did not assess, monitor and mitigate the risks to the health and safety of people living at the home. Records for service users were not accurate or complete and were not always accessible. Regulation 17(2) (a), (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff were supported to be competent and have the skilled to meet people's needs. The training staff received was ineffective. Regulation 18 (2) (a).