Parkcare Homes (No.2) Limited

Bannister Farm Cottage

Inspection report

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Date of inspection visit:
23 July 2018
25 July 2018
10 August 2018

Date of publication:
01 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection at Bannister Farm Cottage on 23 and 25 July and 10 August 2018.

Bannister Farm Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bannister Farm Cottage is situated in a semi-rural area of Leyland, Lancashire. Accommodation compromises of three en-suite bedrooms within the main house and two self-contained annexes attached to the main building. At the time of our inspection there were four people who lived there permanently and one person who attended each week day and stayed overnight every Monday.

We inspected the home on this occasion in response to concerns being identified in relation to another service operated by the same provider and under the same registered manager. However, at the time of our inspection the registered manager was no longer working for the organisation. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The care service is aware of the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. However, we found on this inspection that the service was failing to deliver these values.

We found that people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible, in accordance with the policies and procedures of the home.

During this inspection, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and staffing. We also found one breach of the Care Quality Commission (Registration) Regulations 2009, in relation to notification of other incidents.

Our last inspection of Bannister Farm Cottage was carried out on 7, 11 and 12 December 2017. At that inspection we rated the service as overall 'good.' There were no breaches of the regulations at the time. At this inspection the rating had deteriorated to overall 'inadequate'.

We have considered what action we will take in relation to these breaches. Following our inspection, we met

with representatives of the provider to discuss our concerns and a way forward. The service submitted a robust action plan and have agreed to update and submit this on a weekly basis, until further notice. We have had management review meetings and followed our guidance in the enforcement decision tree.

We have made the decision, based on the level of risk, and engagement by the registered provider to issue requirements to the provider on this occasion, in relation to all breaches identified. However, 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.

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.

New employees had been recruited safely. However, incidents of misconduct had not been managed appropriately and staff members did not feel supported by the management team. Evidence was available to demonstrate there were insufficient numbers of staff deployed, who were suitably qualified, competent, skilled and experienced to meet the needs of those who lived at the home.

Practices adopted by Bannister Farm Cottage did not protect people from the risk of discrimination. Those who lived at the home were not adequately safeguarded from abuse and their human rights were not being appropriately met.

The staff training matrix showed a high number of employees had not completed learning modules in relation to safeguarding adults. We noted there were no systems in place for staff members to summon help when working in isolation and there was little evidence of lessons learned following safeguarding incidents or accidents.
Family members we spoke with did not feel their loved ones were safe living at the home. Risk assessments were not always accurate and up to date, which compromised people's safety and well-being. However, the premises were, in general maintained to a satisfactory standard. However, where it was identified work needed to be done, this was addressed at the time of our inspection.

Emergency plans were in place at the home and systems and equipment had been serviced in accordance with manufacturers' recommendations. However, incidents where injury had occurred had not always been recorded within the accident records.

Simulated fire drills were not always managed effectively and Personal Emergency Evacuation Plans (PEEPS) were not always accurate. This compromised the safety of those who lived at Bannister Farm Cottage.

Records we saw were sometimes vague and confusing. They did not always clearly identify the

circumstances to which they referred. The management of complaints could have been better.

The management of medicines was, in general satisfactory. However, the practices in relation to the administration of PRN medication did not help people to reduce the possibility of heightened behaviours.

The provider was working within the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people were not being unlawfully restricted.

Records showed people were able to choose their preferred diet. However, healthy eating was not regularly encouraged. We saw that nutritious home cooked meals and healthy snacks, such as fruit were served, but not on a daily basis.

We were concerned that the service was failing to be responsive to peoples' assessed needs and choices and person-centred care was not being delivered. People who lived at Bannister Farm were not always treated with dignity, kindness and compassion.

The provider had failed to notify the commission of significant events occurring in the home, such as serious injuries and safeguarding incidents. Arrangements for monitoring and assessing quality in the home to ensure people's safety and compliance with regulations were inadequate. Some audits had been completed, but these were ineffective, as they did not cover a wide range of areas and they did not recognise shortfalls, which were identified during the inspection process. The governance and leadership of the home was poor. Managerial oversight of staff and the care that people received was inadequate.

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

Some relatives felt the service was not safe.

People were potentially exposed to abuse and improper treatment because robust systems had not been implemented to identify and address areas of risk.

People's medicines were, in general managed in accordance with the policies and procedures of the home.

The environment was clean and infection control practices were satisfactory.

The staffing levels and the deployment of staff was not always appropriate. However, staff were safely recruited, but disciplinary procedures were not well managed.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Staff did not receive induction, training or appraisal to help them to support those who lived at the home.

The environment was suitable for those who lived at Bannister Farm Cottage.

Consent to care and treatment was appropriately obtained.

Mental capacity assessments were carried out and applications were made to deprive someone of their liberty, should it be in their best interests.

Is the service caring?

Requires Improvement

This service was not consistently caring.

People were not always treated with dignity and respect.

People's personal information was not managed in a way that

protected their privacy and dignity.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People's assessed needs were not always being appropriately met and how some staff responded to requests from people was inappropriate.

Some records, in relation to people's care and support could have been better. However, some areas were well written and detailed.

There was a clear link between lack of activities, restrictions and heightened behaviour.

There was a complaints policy in place. However, the recording and auditing of complaints could have been better.

Is the service well-led?

Inadequate

This service was not well led.

The provider did not have effective systems and processes in place to monitor and improve the quality of service provided.

Robust systems had not been implemented to mitigate risks and the management of the home did not adequately support staff to deliver safe care.

Some audits had been undertaken, but these were not effective.

There was a lack of oversight of the operation and running of the service.

Bannister Farm 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

A comprehensive inspection took place at Bannister Farm Cottage on 23 and 25 July and 10 August 2018. The inspection was unannounced. This meant no-one knew we were going to inspect the service. It was carried out by three inspectors from the Care Quality Commission. We inspected the home on this occasion in response to concerns being identified in relation to another service operated by the same provider and under the same registered manager.

Prior to our inspection we reviewed all the information we held about this service, which included notifications informing us about significant events, such as serious injuries, deaths and safeguarding concerns. We looked at any information received from other professionals, people who used the service and their family members.

We did not request a Provider Information Return (PIR) on this occasion, as the inspection was arranged at short notice. A PIR is a form that asks the provider to give us some key information about the home, what the home does well and any improvements they plan to make.

We used a planning tool to collate all this evidence and information prior to inspecting the home.

Due to the complex needs of those who lived at Bannister Farm Cottage, we were unable to obtain verbal feedback from them. However, we did speak with family members, an advocate and eight members of staff.

We tracked the care and support of all five people who lived at Bannister Farm Cottage. This enabled us to determine if they received the care and support needed and if risks to their health and wellbeing were being appropriately managed.

We also looked at other documentation, which included medicine records, three staff personnel files,

training information, minutes of meetings, surveys, audits of the service and other quality monitoring systems.

Inadequate

Is the service safe?

Our findings

We were unable to ask people if they felt safe because of their limited ability to share their views with us. However, we spoke with some family members, who felt their loved ones were not safe at Bannister Farm and we noted that robust systems were not in place to protect people from harm. One family member gave us some examples of service user on service user attacks, which resulted in injury. They told us they had attempted to contact senior staff on several occasions to raise their concerns, but this was without success, as their calls were never returned. Another relative told us, 'We have been concerned over the huge amount of staff changes that have occurred at Bannister. The constant change in staffing is not beneficial to an autistic adult, with no speech and severe learning difficulties. We feel the manager and service provider let (name) down badly by not coming to a compromise with unsettled staff. Communication from management is poor and sporadic. We only seem to get meetings or emails when CQC are coming or other agencies. We only request maybe a text message or phone call if there has been incidents involving (name). We have to chase this up too many times. We do not have much confidence in the current management and lack of empathy with parents sticks out. It is only in the last year or so that we have felt helpless and out of touch with (name) care.'

Following the draft inspection report being sent to the service, the provider told us, 'Communication is not only offered to parents when CQC or other agencies are attending. Information is offered to parents to ensure they are able to give their feedback and are aware of the processes. The current on-site manager has met with parents both on-site and at home and actions have been taken to improve communication, based on their feedback. This includes changing the communication log, so parents have more in-depth information about residents' days. Parents have been offered opportunities to attend core team meetings, staff team meetings and menu planning sessions.'

We were told by some staff members they often felt vulnerable and lacked confidence during physical incidents. Records we looked at confirmed that this was due to insufficient training, a lack of support and inadequate emergency systems within the home, which put those who lived at Bannister Farm, staff members and others at risk of harm.

We noted there was no system in place for staff members to summon help when working in the annex buildings in isolation. One record we saw showed a member of staff had 'shouted for help, but no-one came'. This staff member sustained an injury as a result of an incident. The incident record we looked at recorded a date where a debriefing exercise had been conducted, however specific details of discussions had not been recorded.

We found that incident records showed staffing levels, in order to keep people who lived and the home and staff safe were insufficient. For example, there was no allowance for staff to be relieved of their duties in order to take short breaks. Records showed a serious incident had occurred due to one care worker being left alone with a person, who was assessed as needing two care workers at all times. We also noted a complaint had been recorded in relation to inadequate staffing levels, but there was no record to confirm this had been addressed.

We established there to be a high turnover of staff at Bannister Farm Cottage. We were told that 24 staff had left the homes employment in the last year for a variety of reasons, including termination of employment. This lack of regular staff failed to provide a consistent service and stable environment for those who lived at the home.

We noted that agency staff were sometimes used to cover staff shortages, due to sickness, absences or annual leave. We established that temporary staff and new members of staff were occasionally allocated to work with people with the most challenging and complex needs. We were told that some of those who lived at Bannister Farm Cottage reacted negatively to new people and a change of routine. This change from familiar staff to unknown staff heightened people's behaviour and therefore increased the risk of serious incidents occurring. However, we spoke with one agency staff member, who confirmed they had worked at the home several times and were familiar with the person they were supporting at that time. They also told us they received an informal induction when they first started to work at the home, but didn't think this was recorded. They received handovers at the beginning of their shift, which helped them to be aware of recent events. We also observed the agency staff member providing a handover to the oncoming shift.

On one occasion records showed one person, who was receiving 2:1 support refused a night agency worker access to their private accommodation. The night report stated the agency worker was asked to leave, but it was difficult to determine what action was taken to ensure staffing levels remained sufficient to support those who lived at the home. We established this individual was repeatedly asking for food during the night. Therefore, just after midnight staff rang 'on call' to ask for authorisation to administer their prescribed PRN medication, which was approved. We were concerned that this may not have been the best course of action. We discussed this situation with the management team, who assured us they would address our concerns without delay. The staff training matrix showed a high number of employees had not completed learning modules in relation to safeguarding adults. At the time of our inspection we noted only four staff members out of a possible 27 had completed this training within the last 12 months. Staff employed to keep people safe did not have up to date knowledge about how to achieve this.

Records we looked at identified concerns in relation to the management of self-harming behaviours. One person's daily report stated that staff had supported an individual during the recovery phase. This read, 'Calm vocals. Had to lock (name) in for two hours and 30minutes.' Another stated, 'Locked in for nine hours the previous night'. We saw a body map had been completed relating to self-harming during this period, but these were vague and confusing and lacked detail in relation to the circumstances. We discussed these findings with the deputy manager, who agreed that the records could have been more informative. Although, we were subsequently told by the management team that a safeguarding referral had been made in relation to this incident, this had not been reported to the Care Quality Commission, as required by law.

Disciplinary procedures were in place. However, action taken following acts of misconduct were not always dealt with in an appropriate way. This could have placed people at risk of harm.

Our findings demonstrated that at the time of our inspection practices adopted by the home did not protect people from the risk of discrimination. Those who lived at Bannister Farm were not adequately safeguarded from abuse and their human rights were not being appropriately met.

We highlighted our concerns to the management team at the time of our inspection. There was a failure to ensure that people were protected from abuse and improper treatment.

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

Following our inspection, the provider sent us an action plan which confirmed additional safeguarding training had been provided for the staff team following our inspection and confirmed a reflective practice framework would be fully operational by 31 August 2018. This would provide a system for analysing incidents and near misses, in order to aid the leadership and development of the service, whilst maintaining the lowest possible levels of restrictive practice.

A wide range of risk assessments had been conducted in relation to social and personal care needs. These had been reviewed and updated regularly until November 2017, but no reviews had been completed since. The risk assessments for one person showed them to be at 'low risk'. This assessment was now inaccurate, as their individual needs had changed significantly since that time and therefore it was not reflective of current circumstances. This placed people at risk of harm as risk assessments were out of date and these did not reflect their current needs.

Emergency plans were in place at the home and systems and equipment had been serviced in accordance with manufacturers' recommendations. However, incidents where injuries had occurred had not always been recorded within the accident records.

Personal Emergency Evacuation Plans (PEEPs) had been developed for each person who lived at Bannister Farm. However, they had last been reviewed seven months prior to our inspection. It was noted that one person's needs had, significantly changed and therefore the PEEPs for this individual was not accurate. This could have resulted in inappropriate or unsafe support being provided.

A fire procedure and fire risk assessment were in place at the home, which had been produced in easy read formats with pictures, so that those who lived at the home had a better understanding of the fire procedures. The fire risk assessment was due for renewal and we were told any actions as a result of this would be completed by 28 September 2018. However, records showed a fire drill (full evacuation) had been conducted on 21 February 2018. The summary of this simulation read, 'Residents were confused. The location of the fire escape route was obstructed and so had to use external gates.' There was no record of any action taken to rectify this issue or of any lessons learned. Work needed in relation to any actions required was not documented in the maintenance book and the people who lived at the home were not recorded as having participated in the fire drill.

Following our inspection, the provider sent us an action plan, which confirmed PEEPs would be reviewed and updated and monthly monitoring of fire evacuations would take place to include any actions required as a result of the findings.

We were told by staff an internal fire door was not fitted correctly, although the last internal fire door check did not identify any faults. However, on 5 June 2018 records showed that staff had reported this internal fire door was failing to close fully. We discussed this with the management team who confirmed that the fire door was ill-fitting and required attention. On the second day of our inspection the management confirmed a temporary measure had been implemented until a replacement could be fitted. However, this had not been actioned on the third day of our inspection. We discussed this with the management who confirmed the replacement was on site and would be installed imminently. People who lived at Bannister Farm had been assessed as requiring locking systems on the exit doors to keep them safe and to protect them from harm. We saw records that confirmed one person who lived at the home was able to input the code for the exit doors and on one occasion had left the building, which put them at risk of harm. We saw this risk had not been dealt with appropriately by the management team. Records confirmed another person had left the building and was on the road adjacent to the home. This was as a result of a staff member who had opened the gate 'without due care and attention.' This placed people at risk of harm as staff failed to promote the

safety of those who lived at Bannister Farm.

There was a failure to ensure people were protected from receiving inappropriate or unsafe care and support.

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

We saw records that confirmed two people shared one to one support during the night time, which was not always practical, should both people require support at the same time. Some staff members we spoke with felt one person who lived at the home required extra support, particularly when in the community, due to unpredictable behaviour. This was discussed with the management team at the time of our inspection, who assured us that the needs of people would be reviewed to establish the level of support required.

It is recommended a re-assessment be requested of individual needs for all people living in the home to ensure people are receiving the appropriate support they require.

During our inspection we looked at the management of medicines. Staff members told us telephone approval was needed from off-site senior personnel before prescribed as required (PRN) medication could be administered. This often resulted in alternative methods being suggested, such as distraction and diversional techniques, which staff had usually already attempted where behaviours of people were volatile or unpredictable. Therefore, before approval was obtained the volatile circumstances had often escalated due to heightened behaviours, which put people, staff and others at risk of harm.

On the second day of our inspection we were told by management this system had been stopped with immediate effect. However, on the third day of our inspection, a staff member told us that it had been necessary to request a PRN medication for one person by contacting an off-site manager. It was clear that the assurances we had been given about amending practices for PRN administration had not been shared with the staff team. We were assured by the management team that all relevant staff would be made fully aware of the new protocol for the administration of PRN medication without delay.

Protocols were in place for PRN medicines. However, there were no records available to demonstrate best interest meetings had been held in relation to the administration of PRN medicines and the protocols did not identify signs when PRN medicines would be required.

Relevant risk assessments and clear processes were in place for the administration of medicines. Easy read documents had been produced, with a clear description of the medication and the reason for administration, which helped to ensure those who lived at Bannister Farm were involved in the management of their medicines. However, although possible side effects were recorded, these did not relate to specific medicines. Good record keeping and support plans in this area were evident with best interest meetings being recorded in relation to covert medicines (medicines administered with food). Homely remedies had been signed by the GP and any allergies were clearly recorded on admission to the home. Daily audits with accurate balance sheets had been conducted.

However, some minor improvements were needed. For example, the staff signature list did not indicate how staff signed the MAR, evaluations had not been completed since November 2017 and some handwritten entries had not been counter signed, in order to reduce the possibility of transcription errors. The MAR charts were being initialled for the application of topical medicines, such as cream. However, charts specifically for prescribed creams were not being signed. One person was prescribed an 'as and when

required' (PRN) liquid medicine, but the MAR chart did not clearly identify this as a PRN prescription. Protocols for PRN medications were in place. Although these showed the times given and the reason for administration, they did not identify how the staff team would recognise when someone required prescribed PRN medicines.

It is recommended the policies and procedures for PRN medication be reviewed and updated to encompass the revised protocols.

Following our inspection, the provider sent us an action plan, which showed the management of medicines would be closely monitored and improvements made where necessary.

During the course of our inspection we toured the premises and found in general these to be of a satisfactory standard. However, infection control practices could have been better in some areas. For example, the toilet bowl in one ensuite bathroom was dirty, there was a clinical waste bin in the sensory bathroom, a toilet brush was standing in liquid, some taps needed cleaning, a carpet was in poor condition and required replacing and one of the bath tubs had sand in it.

Some maintenance work was also needed. The cooker hob was not working in the kitchen of one of the annexes and a mechanism was positioned in this annex, which if operated would open the doors throughout the building. However we noted the management team addressed these during our inspection.

The last internal maintenance checks of the emergency lighting had been conducted on 26 June 2018. This showed one of the outside lights to be faulty, but there was no record to show this had been rectified. The management team subsequently confirmed this work had been completed.

Records showed a range of internal checks had been conducted regularly. Systems and equipment had been serviced in accordance with the manufacturers' recommendations, although we found that testing of the portable electrical appliances was overdue. On the second day of our inspection the management team had taken action to address this.

A major incident contingency plan was in place at the home, which provided staff with clear guidance about what action they needed to take in the event of an environmental emergency, such as power failure, fire, flood, interruption of the water supply, gas leak or bomb threat.

We looked at the personnel files of four staff members and found recruitment practices to be satisfactory. All relevant checks had been conducted before prospective employees started to work at Bannister Farm. Completed application forms and interview records had been retained in staff files and any gaps in employment had been explored further.

Requires Improvement

Is the service effective?

Our findings

We were unable to ask people about the skills of the staff team because of their limited ability to share their views with us. However, we spoke with some family members, who felt that not all staff were competent to provide effective support to their loved ones.

The provider was aware of specific guidance in relation to Registering the Right Support for people with a learning disability and autism. However, we found this was not being followed in day to day practice. Therefore, effective support was not always being provided for those who lived at Bannister Farm Cottage.

During the course of our inspection we looked at the personnel records of four members of staff. We asked the management about details relating to staff induction. They told us all induction records were kept in staff personnel files. None of the records we looked contained evidence that inductions had been completed. Staff members we spoke with confirmed they did not receive a formal induction when they started to work at the home. One staff member, who had commenced employment in October 2017 had a supervision record, dated 26 June 2018, which stated under 'action required', 'To start induction pack ready for next supervision', despite this staff member having already worked at the home for eight months. The deputy manager explained this was because the current management team were in the process of updating all staff records, ensuring relevant information had been provided consistently across the work force. Therefore, it was clear that new staff had not been formally inducted on commencement of their employment.

There were no appraisal records in any of the staff personnel files we looked at. Therefore, there was no evidence available that confirmed the management team monitored staff progress, performance or their personal development. In one of the files we looked at we saw the staff member had recorded some negative feedback. However, there was no evidence to demonstrate additional support had been provided for this employee or any action taken to resolve the issues recorded.

We looked at the staff training matrix and found some significant gaps, where staff had not received relevant training sessions. For example, the training matrix showed that no staff members had completed learning modules in areas such as, infection control or the Mental Capacity Act and Deprivation of Liberty Safeguards. We did not see any evidence of training specific to the assessed needs of those who lived at the home had been provided, despite their complex needs.

Training in relation to restraint was delivered to the staff team annually. This was in the main theoretical, rather than practical, which was not sufficient for the staff who were providing support for those who lived at Bannister Farm Cottage. Staff we spoke with felt it would be beneficial for them to receive more regular practical training with role plays, in order for them to develop their skills, knowledge and confidence to support this specific client group. The lack of training for staff did not demonstrate that effective outcomes were achieved for those who lived at Bannister Farm Cottage. Our findings demonstrated the provider had failed to deploy sufficient numbers of staff, who were suitably qualified, competent, skilled and experienced to meet the needs of those who lived at the home, and who had received appropriate support, training,

professional development and appraisal, to enable them to carry out the duties for which they were employed. This placed those who lived at Bannister Farm Cottage at risk of receiving inappropriate or unsafe care and support. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with an agency staff member, who had worked at the home several times, but had not been involved in any training at Bannister Farm Cottage. They told us this was not provided by their employer. We recommended that regular agency staff be invited to attend training in relation to the specific needs of those who live at the home.

Following our inspection, the provider sent us an action plan, which showed a full induction and training plan for staff working at Bannister Farm Cottage was to be developed. Additionally, restraint training for staff will be delivered in regular bite size refresher sessions and will include some role play of likely situations relevant to those who live at the home.

Supervision records were evident on the staff personnel files we saw, which showed structured sessions had been held at intervals. This enabled staff to periodically discuss any concerns, training needs and personal development with their line manager. However, the supervision form was somewhat generic and lacked individualisation. Records showed that return to work interviews were conducted following periods of absence by staff, such as sickness or special leave. This helped to ensure employees were supported to resume their duties.

We looked at all five support plans during our inspection. These contained a needs assessment, which included a sensory profile and a physical description of the individual that would support the identification purposes of them.

We established one person received consistent observation from two members of staff during the day. However, this high level of support ceased at 10pm, despite the individual routinely not sleeping until the early hours of the morning. Therefore, when this person required support after 10pm, then this was drawn from other people's staffing resources.

It is recommended that a request be made to the funding authority to reassess this person's needs, with the possibility of increasing 1:1 support from 10pm. Records showed people were able to choose their preferred diet. However, healthy eating was not regularly encouraged. We saw that nutritious home cooked meals and healthy snacks, such as fruit were served, but not on a daily basis.

Following our inspection, the provider sent us an action plan, which showed that support workers and those who live at Bannister Farm Cottage will work together to identify food preferences and healthy options, in order to promote good nutrition.

We were told the Speech and Language Therapist had arranged some specific training in relation to meals provided to people, which was open to family members. This would help the staff team and relatives to better understand the importance of ensuring appropriate diets were provided.

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 or 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 to see if the provider was working within the principles of MCA.

During the course of our inspection we looked at how people's capacity was being assessed and if decisions had been made in their best interests. We found some of these records were out of date and some decisions had been made without the involvement of the individual, their family or significant others. There were no best interest records in relation to specific decisions, such as the administration of PRN medication. In some cases, this was addressed at the time of our inspection and therefore some updated mental capacity assessments were introduced. However, others remained outstanding.

Deprivation of Liberty Safeguard (DoLS) applications had been made to the local authority and some were awaiting approval. This helped to ensure people were not being unlawfully restricted. However, we noted one DoLS application did not provide accurate information in relation to the use of restraint.

Records showed consent had been obtained from people before care and treatment was delivered. However, this documentation was not always clear, as sometimes referral was made to other records and not those important to the specific decision. For example, one person's consent records had not been reviewed since August 2017 and therefore did not include their Lasting Power of Attorney.

Following our inspection, the provider action plan which verified that all mental capacity assessments, best interest decisions and Deprivation of Liberty Safeguard applications have been completely reviewed and updated.

Requires Improvement

Is the service caring?

Our findings

We were unable to ask people about the care they received because of their limited ability to share their views with us. However, we spoke with family members, who felt that some staff were kind and caring, but that other did not demonstrate compassion or empathy. We observed some staff members approaching and interacting with people in a kind and caring manner, whilst others failed to support independence or respect.

On the first day of our inspection a new care worker arrived for duty. It was their first shift. We observed them being provided with people's care files to read. These records contained some highly sensitive information about those who lived at Bannister Farm Cottage and therefore it was not appropriate for the managers to share this information with a new starter prior to a full induction being completed, which should include guidance around confidentiality and data protection.

Policies were in place at the home in relation to equality, diversity, advocacy and social inclusion. However, our observations during the inspection did not always support the care plans or policies of the home. We found not all staff provided people with emotional support when they needed it and some did not approach those who lived at Bannister Farm Cottage in a respectful and compassionate manner. For example, we saw one member of staff inappropriately stopping a person from making reasonable choices, which resulted in an escalation of their behaviours. Another staff member was seen making a person sit down for lunch by banging on the table. A member of staff had made a night entry in the daily reports for one person, which recorded they had attempted to take staffs' food, but this was 'wrestled' off them. Later that night the person asked for a biscuit, but was told to wait for morning. This did not promote kind and caring attitudes towards people who used the service.

We discussed our observations with the management team at the time of our inspection. We were assured the staff team would receive further learning around privacy, dignity and respect. The action plan submitted following the inspection also confirmed that staff would be observed at work and would be supported to improve general practices.

It is recommended the staff team receives training around privacy, dignity and respect and are supported to make appropriate entries in the care records.

We established that an advocate supported one person who lived at the home. An advocate is an independent person who helps to ensure decisions are made in people's best interests. Relatives we spoke with felt that better lines of communication could be established. Family members told us they needed to be assured their loved ones were safe and happy, whilst they lived at Bannister Farm Cottage and that they were kept informed of changes in care needs and any significant events. However, they did not feel this support was forthcoming by the management of the home.

It is recommended that relatives be kept informed of their loved one's progress and are supported to feel involved in their care and treatment.

People's choices and preferences were clearly recorded. However, it was not evident these were being met in day to day practice. For example, the support plans we saw recorded people's preferred leisure activities, but there was no evidence to show they were being supported to maintain some of these interests.

However, during our inspection we observed some staff members approaching people in a sensitive manner and the support plans included guidance around effective communication. These were found to be detailed and contained a lot of good information to enable effective relationships.

We noted a range of documents were produced in an easy read format with illustrations. This enabled people to access relevant information and supported those who lived at Bannister Farm Cottage to be provided with equal opportunities.

Records showed those who lived at the home or their families had been provided with relevant information about Bannister Farm Cottage and were involved in the care and support of their relative.

Requires Improvement

Is the service responsive?

Our findings

We were unable to ask people about their assessed needs because of their limited ability to share their views with us. However, we spoke with family members, who felt some staff were responsive to people's needs, but others did not promote person centred care and support. At the time of our inspection we observed people who used the service did not always receive person cantered care, in accordance with their support plans.

We discussed the assessed needs of one person at length with the management team and staff members. We were concerned that this person's needs were not being appropriately met. We felt staff were attempting to meet assessed needs, but that additional support was required. Specialist health investigations were needed to enable individualised care to be provided in the persons best interest. However, although we saw that there had been communication with specialist health care professionals about the treatment required, specific arrangements had not been confirmed or followed up appropriately.

We found that any known allergies had been recorded on admission to Bannister Farm Cottage. However, this information was not highlighted elsewhere in the care files. Regular reviews of the support plans were limited and the records of daily events were not always clear. Some entries were illegible and others were confusing. Care charts were not always up to date and some had not been completed for several weeks.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible, in accordance with the policies and systems in the service.

We were concerned that the service was failing to be responsive to peoples' assessed needs and choices and person-centred care was not being delivered.

We saw one person had limited access to leisure opportunities, which had decreased significantly since our last inspection. Their weekly activity planner failed to reflect the reduction in activities or the current assessed needs that were not being appropriately met within an acceptable time-frame.

Records we looked at identified a clear link between the lack of activity, restrictive practice and their heightened behaviour. For example, the records for one person showed their bathroom door was locked after staff have documented they were, 'messing in the toilet.' The following day no activity was recorded, resulting in a significant increase in negative behaviour.

We were told another person's behaviours heightened when staff restricted their meal times. Records we saw confirmed this to be accurate information. One member of staff stated, "If [name] wants lunch at 11.30am and cannot have it, they will escalate." Records for this person showed incidents of restrictive practice involving food resulted in heightened behaviour and consequently staff injury.

The records for one person showed they often went a drive with staff in the minibus. It was clear from the

records that these activities were thoroughly enjoyed by them. The regular trips out into the community helped them to relax and therefore reduced the incidence of heightened behaviour. Daily records showed they had recently asked to go for a drive with staff. The entry read, '[Name] was redirected and told to rest. They were not listening, as they did not want to relax. They still wanted to go for a drive. Staff tried to redirect, as they [the staff] were cleaning.' Records for this person showed this resulted in their heightened behaviour.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider sent us an action plan, which identified a lifestyle co-ordinator was to be appointed to take the lead on the arrangement of activities and positive risk taking.

The action plan also stated everyone's support plans would be reviewed and updated at monthly intervals, or when people's needs changed. It also confirmed that the care charts would be checked daily by a member of the management team to identify any gaps or concerns, which would be discussed at flash (daily team) meetings.
We saw records to demonstrate that quality walk rounds and flash meetings had been introduced, which incorporated areas, such as infection control practices and good governance. Additional observations were to be introduced by the management team with immediate effect. As a result, extra coaching, where needed will be provided to staff members on an individual or group basis. We saw a document in one person's care records, which recorded their specific goals in life. However, there was no evidence to show if these had been reached, or how the individual was being supported to achieve their aspirations. Old records showed that a system had previously been in place, which held some good information about activities, outings and achievements. However, the last entries were recorded in 2015. Therefore, these were not current.

It is recommended that all records be reviewed and updated, to ensure current information is provided for the staff team.

Some parts of the care files we saw could have been more detailed. For example, the one-page profiles contained limited information, but the essential life style plans were more informative and provided the staff team with clearer guidance about people's needs.

Following the inspection, the provider sent us an action plan, which showed that all one-page profiles would be reviewed and updated by 24 August 2018.

The care file for one person who lived at the home read, 'Prior to informing me it is time to do an activity my staff are to ensure they have read, understood and signed my activity protocols and risk assessments.' Three of this individual's support workers had signed these records, which were detailed and informative. One part of this person's care records provided staff with clear guidance about how autism affected the individual, which encompassed social communication, imagination, flexibility of thought, social interaction and sensory impact.

The support plan for this person recorded, '[Name] choses their own clothes and gets themselves dressed.' The support plan for this person encompassed a wide range of activities of daily living, such as mobility and transport, health and medication, safety, advocacy, nutrition, hobbies and interests and behaviour support. Each person who lived at Bannister Farm Cottage had a person-centred incident folder, which identified any known triggers or warning signs to indicate when behaviours may escalate. We saw detailed descriptions of incidents occurring with action taken being clearly recorded. Any injuries were outlined on body maps,

medication administered was clearly recorded and any medical attention sought was evident. However, despite this information being in place, there was still evidence of heightened behaviours. The documentation used for this purpose did not sufficiently allow for details of debriefing sessions to be recorded or for lessons learned to be discussed with the staff team and clearly documented.

Following the inspection, the provider sent us an action plan, which confirmed that debriefing sessions would be introduced with immediate effect, in order to support staff. It also stated that discussions would take place with the staff team around lessons learned following incidents. This would help the staff team to move forward and to improve the management of incidents.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information they can access and understand, and any communication support they need. We looked at how the provider shared information with people to support their rights and help them with decisions and choices. We saw some information had been produced in easy read formats to meet the communication needs of people who lived at Bannister Farm Cottage. We were told that the provider was looking at improving the use of technology within the home, in order to move the service forward.

A written policy was in place at the home, which provided people with the information required in order to make a complaint. This incorporated timeframes for responses of outcomes and contact details for relevant external organisations.

There was a system in place for the recording of complaints received. However, this was found to be very disorganised and contained some documentation about another service. Therefore, a clear audit trail was not evident and there was no record of lessons learned to aid in moving the service forward in relation to the management of complaints.

Following the inspection, the provider sent an action plan which showed the issues identified around complaints would be addressed by 13 September 2018.

Inadequate

Is the service well-led?

Our findings

We were unable to ask people about the leadership and management of the service because of their limited ability to share their views with us. However, we spoke with some family members, who felt the management of the home could be improved.

The provider was aware of specific guidance in relation to Registering the Right Support for people with a learning disability and autism. However, we found this had not been embedded throughout the processes adopted by the home.

Staff we spoke with felt there was a lack of management support. We were told that concerns had been raised about insufficient training around supporting one individual with complex needs. They said that managers were dismissive and their concerns had not been taken seriously. Therefore, additional training had not been provided.

Some audits had been conducted. However, these were not sufficient in detail and did not encompass a wide range of areas, which would have provided a more in-depth managerial oversight of the service.

There were no structured audits of incidents in place. Therefore, these events were not being closely monitored or analysed, in order to extract relevant information, such as specific themes or recurring patterns. The medicine audits and person-centred care plan audits failed to identify the shortfalls we identified during our inspection. Therefore, these were not effective.

All care files we saw instructed staff members to sign the support plans to indicate they had read and understood the contents. This was not being done in practice. For example, no staff members had signed the support plans for one person who had complex needs and only four staff members out of a possible 30 had signed another support plan. There was no management oversight to monitor this process. The people who lived at Bannister Farm Cottage had high level, complex needs and staff not being aware of these needs could result in inappropriate or unsafe care and support being provided.

The care charts retained in people's bedrooms and the daily records were not being consistently completed and therefore a full picture of people's care and support was not evident. Body maps had been introduced when needed and these were being completed on a daily basis. However, they only showed new marks to the body and did not record the progression of existing ones.

We found the home lacked robust management systems and the staff team were not appropriately supported to care for people in the most effective way. There were no records kept of lessons learned following incidents, accidents or safeguarding events.

A team away day for managerial and senior staff had been held recently. We were told the aim of this was to support management and the senior teams to identify the purpose of their role and develop an action plan. This was to enable creating successful, proactive and person-centred service provision through good

leadership, communication, coaching and mentoring of the staff team. The outcome of this was to ensure people using services would be supported in ways which reflected their needs whilst ensuring they remain safe and well. Our findings at the time of our inspection did not support this was happening in day to day practice.

At the time of our inspection we found there was a significant lack of managerial oversight of Bannister Farm Cottage. The systems for assessing and monitoring the quality of service provided were weak and management support for those who lived at the home and the staff team was poor.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the time of our inspection, additional managerial support had been secured two days every week and an action plan had been developed, this was being submitted regularly to the CQC. We were shown an example folder of paperwork, which the provider intended to introduce, in order to improve the process of assessment and quality monitoring.

Providers of health and social care services are required by law to notify the CQC of significant events that occur in their services, such as serious injuries to people and allegations of abuse.

The provider had failed to notify the CQC of all safeguarding incidents and there was no evidence of correlation, in order to identify possible themes and trends. There were no records available to show what lessons had been learned following safeguarding incidents and there was no oversight from senior managers to ensure the service was compliant with this regulation.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection, the provider sent us an action plan, which indicated that all safeguarding investigations would be overseen by the management team and reported appropriately with immediate effect.

At the time of our inspection there was no registered manager appointed. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The senior management team told us recruitment of a suitable manager was in progress.

One incident record we saw showed a member of staff had received some injuries during an attack on her. Following the inspection we were told this member of staff was taken to hospital by a colleague to be checked over.

We were told that the management team had little involvement with those who lived at the home and that staff involved in incidents were subsequently never asked if they were 'alright.' However, staff we spoke with felt they worked well together as a team and supported each other. We saw evidence of night checks being conducted by the deputy manager.

We saw that governance meetings were held periodically, which included discussions around safeguarding, infection control, health and safety, medicines management, complaints and staffing. However, we identified a significant number of gaps in processes, which did not demonstrate effective systems had been

adequately implemented.

Records showed that staff meetings were held periodically. The most recent being the day following the first day of our inspection. This was an in-depth discussion, covering autism reflection, team working, health and safety, staffing, training, employee of the month and a discussion around individual service users.

At the last meeting staff were encouraged to be open and honest about the service with the inspectors and for them to see the inspection process as a supportive one. Staff were told that feedback from inspectors will be shared with them and that the team will be involved in improving service delivery. An action plan was developed from the discussions held at this meeting. This would help to move the service forward in a pro-active way and make improvements as needed.

A wide range of policies and procedures were in place at the home and a statement of purpose had been developed. These documents included diversity and inclusion, advocacy, equal opportunities and social inclusion, the aims and objectives of the home and the visions and values of the service.

We established people's personal allowances were retained securely in the main office. However, this was not open during the evenings and at weekends. Therefore, we were told people were not able to access their own monies during these periods. We discussed this with the management team who confirmed that if people wanted money during out of office periods, then petty cash was available in the main house for this purpose.

It is recommended the staff team be aware of correct processes for people's personal expenditure during out of office periods.

A maintenance request log had been developed within the home, which showed the date of when work had been completed. However, the last entry was 25 May 2017. Managers we spoke with confirmed work had been done since then. Therefore, this record was not up to date and, as entries had been missed and so there was no audit trail of maintenance work requested and completed.

It is recommended that all maintenance records be kept up to date, to ensure a clear audit trail is maintained of work completed.

Staff we spoke with told us they had made suggestions to the previous management team, but their ideas were dismissed. For example, the code to the exit doors should be periodically changed, the garden gate needed to be secured and the installation of Close Camera Television (CCTV) to the external grounds were some suggestions made. However, we were told management had not listened to their ideas and this had an impact on those who lived at the home. For example, the incident where one person left the premises and the grounds.

On the last day of our inspection we were made aware of the introduction of a traffic light system, which encompassed how people presented when at their baseline behaviours, when experiencing various levels of anxiety and how to recognise when people's behaviours were escalating. These records provided staff with clear guidance about what action they needed to take at each stage, in order to reduce people's level of anxiety and therefore reduce the possibility of harm to the individuals, the staff team and others within the vicinity. The actions included areas, such as systems now in place since our inspection for staff to summon help, familiarity with support plans and risk assessments, access to food when required and snacks during the day, engagement and the provision of activities and to offer PRN medication when necessary.

The action plan submitted by the provider shortly after our inspection showed that on completion of all the actions a sustainability plan will be devised. This would include the implementation of the monitoring tool and a full quality audit.

Following the inspection, we met with the provider's representatives and they informed us they would be taking robust action to address all the shortfalls we identified. They submitted an action plan on how they intended to address all our concerns. It was agreed that updated action plans will be submitted on a weekly basis until further notice.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission of significant events that had occurred, such as serious injuries and allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to implement robust systems, in order to ensure peoples' assessed needs were responded to appropriately and person-centred care was delivered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure systems were in place to mitigate the risks to people's health and safety and therefore people were not adequately protected from receiving inappropriate or unsafe care and support.

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 The provider had failed to effectively safeguard people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems had been implemented to assess, monitor and improve the quality of service provided. There was poor managerial oversight of how the service was being run.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure the staff team were skilled, knowledgeable, experienced and sufficiently trained to support those in their care.