Alo Care Ltd

Ado Lodge

Inspection report

53 Ramley Road
Lymington
Hampshire
SO41 8GZ

Tel: 01590679089

Date of inspection visit:
23 February 2017
01 March 2017

Date of publication:
08 May 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on 23 February and 1 March 2017. The inspection was carried out as a result of concerns received about the service.

Ado Lodge is a care home service without nursing, which provides personal care and accommodation for up to four younger adults with learning disabilities or autistic spectrum disorder.

There were three people using the service at the time of this inspection.

The service had a registered manager in post. A registered manager is a person who has registered with 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.

Although there was a registered manager in post they were currently absent from the service. The provider had put in interim management arrangements. The home also employed a home manager. This role was intended to have a lead role in day to day management within the home.

Experienced staff were not always deployed in sufficient numbers to keep people safe.

People were not fully protected from the risk of avoidable harm and abuse that may breach their human rights because staff did not always receive appropriate training in a timely manner.

The system for checking staff's suitability for their role before they started working at the home was not robust.

Medicines were not all stored, administered and managed safely.

People were not always supported by staff who had received appropriate training, professional development and supervision to enable them to meet people's individual needs. There were not always enough qualified and experienced staff to respond to and meet people's needs.

A regular team of staff had developed positive caring relationships with people, knew people well and respected their privacy and dignity.

People's care needs had not been reassessed regularly and this had put them at risk of inconsistent care or not receiving the care and support they needed.

The systems used for recording people's care and support had changed frequently and had not supported staff to provide individualised or person centred care.

The complaints system was unclear and had been managed inconsistently.

Management systems were not effective in ensuring the quality and safety of the service. Incident reporting systems were not robust.

The registered manager had not promoted a positive, open and inclusive culture at the service. Staff did not receive appropriate support and did not feel well informed.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in relation to the service. The provider had not informed the CQC of a number of significant events.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach under the Health and Social Care Act 2008 (Registration) Regulations 2009.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not always deployed in sufficient numbers in a way that kept people safe.

People were not fully protected from the risk of avoidable harm and abuse that may breach their human rights because staff did not receive appropriate training in a timely manner.

The system for checking staff's suitability for their role before they started working at the home was not robust.

Medicines were not all stored, administered and managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not cared for and supported by staff who all had relevant training, support, supervision and appraisal.

Staff had not all been supported to understand their responsibilities in relation to consent and supporting people to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not set up systems to support staff to provide good care.

A regular team of staff had developed positive caring relationships with people.

Staff knew people well and respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs had not been reassessed regularly and this had put them at risk of inconsistent care or not receiving the care and support they needed.

The systems used for recording people's care and support had changed frequently and had not supported staff to provide individualised or person centred care.

The complaints system was unclear and had been managed inconsistently.

Is the service well-led?

Inadequate

The service was not well led.

Management systems were not effective in ensuring the quality and safety of the service.

Incident reporting systems were not robust and were inconsistent.

Staff did not receive appropriate support and did not feel well informed.

The registered manager had not promoted a positive, open and inclusive culture at the service.

Ado Lodge

Detailed findings

Background to this inspection

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

We visited Ado Lodge on 23 February and 1 March 2017. The inspection was unannounced on the first day. We announced when we were to be inspecting on the second day, however staff were not informed of this and there was no provider's representative present.

Before the inspection, we checked the information that we held about the service and the service provider, including any notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law. We also contacted a person responsible for commissioning services from the provider.

None of the people who used the service were able to communicate verbally with us. We spent time observing how staff provided cared for people to help us better understand their experiences of the care and support they received. We spoke with the home manager and six members of the care staff team, an interim manager and one of the directors. Following the inspection visit we contacted two relatives who provided us with feedback about the service.

We looked at available documents and written records including people's care records, risk assessments and medication charts. We also looked at information regarding the arrangements for managing complaints and monitoring the quality of the service provided within the home.

Requires Improvement

Is the service safe?

Our findings

A relative told us "Over the past year I have been extremely concerned about the service". They had contacted the provider and external agencies about these concerns. "At one point he seemed to be suffering, picking up on a difficult situation, distressed though not mistreated. Staff changed like the hands of a clock. During this time there has been a core of care staff who care very much, second to none. They were so nice to him. It was the management I had issues with".

At other times the service was "grossly understaffed". For example one morning there had been two staff to support four people. This meant there would not have been enough to provide the one to one and two to one support that people were assessed as needing.

Items in place to keep people safe were not repaired with people's safety in mind. A relative told us the person had been sleeping on a broken bed. When a care worker discovered this, the legs were taken off to make the bed safe. The bed had now been replaced. A gate that was in place to keep people safe was also broken and another gate was not secured. Although these issues were rectified, it was not possible to determine how long they had been broken before action was taken.

The situation had recently improved: "If he is going to be safe and cared for, I will be happy for him to be there".

Before the inspection we had received concerns from partner agencies in relation to physical interventions being used which may be outside of the care plans. The provider used a specific training programme to equip staff to respond appropriately to behaviour that people may find challenging. However, not all staff who worked in the home had received this specific training. The training was not being provided in a timely manner to support staff to safely meet people's needs. Two people had care plans that outlined the use of physical restraint if required. It was difficult to review all the care plans as the provider's head office had taken them to scan and place on the new electronic system. The care plans we were able to see were clear and easy to follow. We spoke with four staff and they were clear that physical restraint would only be used as a last resort. Staff we spoke with were aware of the importance of not taking part in restraint if they had not received the training. However, one such member of staff had been the driver with one other trained staff taking out two people in the community. This meant there would not have been sufficient suitably trained staff available to support the people at all times safely.

Although there were sufficient staff to meet people's basic care needs, they were not always deployed in a way that kept people safe. Some staff were working long hours / additional shifts. For example, one member of staff told us they had worked 70 hours over the previous seven days. We were told rotas were organised via a mobile phone application ('rota cloud'). We were able to see staff allocation records on paper that indicated staff attempted to ensure there were sufficient numbers of staff with the necessary skills, such as positive behaviour management, epilepsy, car drivers. The paper records were not always fully completed. We did not have access to the full rota so we could not see how staffing was monitored. It was not possible to fully understand how staffing was assessed or get a complete overview of staffing from

information held at the home.

Daily staff allocation records were available for most shifts, however these did not demonstrate how staff cover was planned in advance to ensure people's needs and activities were met by suitably trained and experienced staff. Staff were able to pick up shifts via a mobile phone app and see who was on duty across the provider's services. The app could calculate the hours staff worked. It was not clear from talking with staff if or how this was monitored by management. Not all staff allocation records were on file or complete.

There was a breach of regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acknowledged that in addition to basic minimum standards of care, other aspects of support had been commissioned by the commissioning body to meet individuals needs. The levels of care and support were being reassessed to ensure that what had been commissioned and paid for was being provided. The provider sent us copies of rotas showing how staff were now being deployed to meet these needs.

There were no records of staff recruitment checks kept in the home. We were sent a copy of an audit of Disclosure and Barring Service (DBS) checks carried out at the provider's head office since concerns were raised. This indicated there were gaps in the evidence held at head office. The provider informed us that all existing staff files were being audited for compliance with the regulations. The provider's action plan included a review of staff interview techniques and procedures. It was clear from this information that a number of staff had been working in the home without appropriate checks in place, which placed people at risk of harm. There was no evidence provided to show that management had taken any action to manage the risks this presented.

There was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we spoke with a core group of staff who had worked in the service for several years. The staff we spoke with had an understanding of their responsibilities for reporting accidents, incidents or concerns. They knew how to report any suspicion of abuse so that people in their care were protected. Staff confirmed and records showed the majority of staff had completed online training in safeguarding adults as part of their training. A senior member of staff said they were confident that they and other staff would report any safeguarding issues to the home manager and/or the interim manager.

Subsequent to the inspection, the provider told us they were making improvements to further ensure staff were supported in understanding and following safeguarding procedures. This included training all staff in relation to a reviewed and more specific safeguarding policy relevant to the service, and to make available a clear flowchart for any member of staff or person using the service who suspected abuse to be able to report it in an effective and confidential manner.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. A person's behavioural support risk assessment specified what planned and least restrictive physical interventions may be employed as a last resort. These included breakaway techniques and safe holding techniques such as a two person assisted move.

The risk assessments were detailed and gave staff guidance about how to deal with situations. Occasionally people became upset, anxious or emotional. Staff were aware of the potential triggers for these situations

and knew how to respond in the best way to support the person.

Peoples' medicines were not always managed and administered safely. Each person had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. Where people were prescribed 'as required' or PRN medicines to manage pain relief or behaviour which might challenge others, there were PRN protocols in place. Staff were aware of these and were able to consistently describe the circumstances in which they would administer PRN medicines. However, the home manager told us they had to phone the registered manager before they could give a person a mild analgesic PRN, which meant the person could suffer because of the delay or there could be an incident of challenging behaviour.

Medicines were stored within individual locked cabinets inside a locked medicines/treatment room. We carried out a stock check of Controlled Drugs (CD's), which are medicines controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. It was not clear if the CDs were stored in appropriate storage within the individual medicines cabinets. While the CD register tallied with the number stored within the CD boxes the register's index had not been updated regularly. The home manager took immediate action to seek advice from the local pharmacist on the safe storage of CDs and updated the CD register index.

Interim management later confirmed that further medicines training and competency assessments would be carried out, as well as an audit of medicines management. GP medicines reviews were also being scheduled.

Requires Improvement

Is the service effective?

Our findings

Before the inspection we had received concerns from partner agencies in relation to a lack of key training for staff, including training in specific physical interventions and epilepsy.

We spoke with three staff, one of who had started work in May/June 2016, one in November 2016 and the other in January 2017. None had yet had their positive behaviour management (PBM) training. The person who had started at the beginning of November stated "I have had no further training since my induction". However all three staff said they found the induction training informative and comprehensive. The new member of staff who commenced in January said they were now on various training courses over the next two weeks. This had recently been arranged by the interim management.

There were gaps showing in the training records sent to us and this was confirmed by the interim manager. Of particular concern was the delay in staff, who had worked at the service, receiving physical interventions training and also epilepsy training.

A member of staff from another of the provider's services came on duty to assist on an outing. They had started working for the provider in November 2016 and had worked at the home on previous occasions. They confirmed they had received PBM training the previous week, epilepsy training on 27 February 2017, and recent training in relation to administering medicines for epilepsy. A senior member of staff told us "We need a list of everyone in the company and what training and skills they have, in order to know if they are suitable for the role and if there is any support they need". Such a list was not available in the home.

The provider and interim manager were open and confirmed that there were issues with staff training and this was being addressed. They sent us a record of training that was booked between 28 February and 31 March 2017. The provider's action plan stated Care Certificate induction workbooks were also to be implemented. The Care Certificate is designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that are expected to be upheld.

Staff and the home manager confirmed that staff supervision and appraisal had not been taking place. Records were not available after June 2016. Interim management informed us this was now being scheduled. Supervision and appraisal provide opportunities for management to meet with staff, give feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop.

There was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

A person's care record showed that a best interest decision had been made by their dentist following consultation with the person's advocate, GP, and staff. Staff told us another advocate had now been appointed for the person who did not have any relatives involved as powers of attorney in their care and support.

The staff training matrix indicated six out of eleven staff had received face to face training in the MCA and DoLS. There were also some gaps in the record of online training. The home manager confirmed they had attended MCA training facilitated by an external company on 22 February 2017. Following the inspection the interim management informed us that further MCA and DoLS training would be rolled out to all staff.

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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

All the people in the home had restrictions in place on how they lived their lives. People were under constant supervision and there were coded doors and locked doors to keep people safe. Applications for DoLS for people who lived in the home had been applied for. We saw documents to confirm this in people's care files. We saw that the provider had routinely followed up outstanding applications with the appropriate local authority, most recently in January 2017.

However, staff were not supported to understand restrictions to people's liberty. The home manager said they had not been involved or informed about management meetings in relation to DoLS, which meant they had not been supported to understand their legal obligations under the Deprivation of Liberty Safeguards. This meant people could not be confident that staff knew what this meant for any individual restrictions on their liberty.

People were supported to eat and drink enough to meet their needs. Staff provided people with different food options, through the use of pictures, so that they were able to make an informed choice. There was an information board in the dining room that showed the foods that individuals preferred or that should be avoided. People were encouraged to prepare their own meals and drinks with staff support and supervision in the kitchen.

Individual menus were not always followed . A parent / relative told us they had discussed their son's dietary needs and preferences and had been sent a "wonderful menu" by the provider, but staff had confirmed that was not what people were eating: "They eat nicely, but not that!"

The available records indicated that people's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A consultant had reviewed a person's medicines in September 2016 and noted improvement in the person's condition and behaviour.

Healthcare information was incomplete giving an unclear picture of people's healthcare needs. People had health care folders, which showed when appointments such as dental examinations were due. The records contained sections that had not all been completed. For example, a person's health passport was blank. An optician had made a prescription but there was no record of any follow up action. A speech and language

therapist (SALT) had recommended the use of a social story to support a person with personal hygiene. Social stories are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and why. A member of staff confirmed this was used. A record in the home indicated that not all staff had received the training in relation to using this technique and this was confirmed by the home manager. This meant the person was not supported consistently with their personal care needs.

Requires Improvement

Is the service caring?

Our findings

One relative told us "Last year he never had his birthday day out. I was told this would only happen if I paid for a second member of staff. I paid then received a phone call to say there was insufficient care staff. He never had a birthday treat. No one mentioned the payment so I had to deduct it from the next payment".

Although the staff worked with people in a caring and compassionate way, the provider and registered manager had not set up systems to support this. Staff had not always been deployed in such a way as to support people safely with their activities or promoting people's choice. We were told by partner agencies that people could return home earlier than agreed times. This meant people could become upset and distressed.

A core team of regular support staff had developed positive caring relationships with people using the service. This was confirmed by the relatives of two people. A relative said they were "Very good, I can't speak highly enough of them. When things were at rock bottom they were my rock". They added "They took the people on holiday and everyone really enjoyed it".

We asked another relative about the care being provided and they told us "It's excellent". They told us that when the person had moved to Ado Lodge from another placement, staff had recognised the person needed more interaction and stimulation. "He's come on leaps and bounds, from a potentially depressed and aggressive individual to a very happy person". For example, following a visit to the family home, the person had told them he was ready to go back to Ado Lodge. This was something he had never done at previous placements. The relative said their family member had been "Happy over the last three years and in the last three months even more so". Their family member and another person living at the home "Appear to be getting on like a house on fire". The person, who had become more sociable, had gone to a "Christmas party and was dancing and had a lovely time. Not the (person) I know!"

They also spoke positively about the team of regular staff at the home. They were "Impressed by the home manager, who is quick on the uptake". The home manager had "Picked up a lot of (the person's) characteristics" and was "An effective carer". They also mentioned a senior support worker who also "Is absolutely brilliant" and "can talk to (the person) about programmes they both used to watch". Two other support workers were also mentioned, who "Can communicate and converse with (the person)".

People appeared comfortable and at ease in the home and with staff. The atmosphere throughout the home was friendly and caring. The core staff team had got to know people well and knew their individual communication skills, abilities and preferences. Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. We observed that staff were respectful and supporting people in ways that upheld their dignity and promoted their independence. The home manager was keen on encouraging people to maintain and develop daily living skills for independent /supported living, such as household tasks and meal preparation.

A relative said they had been involved in the person's care and support planning with staff. They had

informed staff that the person needed more support with personal hygiene, as they were unable to do some tasks independently as was stated in the care plan at the time. Staff had engaged and communicated effectively with the person and this had improved. They felt they could raise issues with the staff in the home and the staff would listen and deal with matters they raised.

Requires Improvement

Is the service responsive?

Our findings

There was a lack of consistency in how well people had been involved in developing their own care and support plans and the reviewing of these. People's care needs had not been reassessed regularly and this had put them at risk of inconsistent care or not receiving the care and support they needed.

Care reviews and meetings between people and their key workers had not been taking place. The interim manager informed us this was now a priority. A relative confirmed they had visited the head office that day for a review of the person's care, which had not been happening previously. The meeting had left them feeling "cautiously optimistic, after all the broken promises of the past year, they will do the things they are saying". They told us the registered manager had said they would sort out gym activities for the person but never did this. They had now met the interim manager, "a lovely person".

Another relative told us they had attended a parents meeting the previous night that had been arranged by the new interim management. They said "In my experience reviews are only requested by the adult social services". They had been invited to a recent review with the person's social worker and this had been a positive experience. Following a previous review at the provider's head office, they said "The results were not transmitted to the service". For example, when they had raised an issue about the person's increasing weight, this had not been passed on to staff in the home to be aware of and support. With recent changes in management arrangements, the person was now supported to maintain a healthier weight.

We were able to speak with some of the staff who worked at the home. The more experienced staff demonstrated some knowledge of how to support people, what the risks were, including triggers for behaviours that might be challenging. However, as the reviews had not been taking place and records were not always complete, it was not possible to check this was the most up to date picture.

Care and support plans were not always available, as sections had sometimes been removed by head office staff to take to the head office and upload on the computer system. These were not always returned promptly and there were no checks to ensure records were complete following this process. It was not possible to establish what sections were missing and how long they had been missing for. For example, a section on current and previous interventions and how successful they were was blank. The interim manager confirmed another section existed and said she would find it as sections had been sent to head office. There had been a lack of feedback regarding incident forms staff sent to head office. This meant staff were not supported to keep up to date with current needs, the strategies for meeting them and could not easily identify trends and changes.

The systems used for recording people's care and support had changed frequently and had not supported staff to provide individualised or person centred care. A member of staff showed us a new computer system for recording care notes that had been in place for two days. Not all staff were fully trained in the new system. Staff had individual pass codes and could record daily notes. One person's fluid intake was being recorded, however staff were unable to tell us the exact purpose of this. The computer system previously used by staff did not allow them to access or amend their notes once they had entered them. This included

incident forms. Staff did not know what happened to the forms once they had submitted them.

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

We saw examples of more recent care and support plans that were clear and descriptive, for example about the person's medical background, personality and needs. The records included a positive behavioural support assessment that described what motivated the person, the risk factors of challenging behaviour and conditions under which challenging behaviour was less likely to occur. One section regarding current interventions was blank.

A risk assessment stated that a person had a social story read to him in relation to personal care. Not all staff had received the training in using social stories. A member of staff demonstrated their knowledge of the support plan for giving the person options about the method of washing and who they wanted to support them with personal care.

Changes were made without consultation with the person or their representative. One person had not been supported to use and maintain links with the wider community. A relative told us the person had previously enjoyed going to a day service that offered particular activities. Neither the parent nor the commissioner had been informed that the person was no longer going to this day centre but was being taken to the provider's own day service. Since then the person had been gaining weight, as they were not getting the exercise and stimulation, but "Eating his sandwiches in the back of the car". The situation had recently improved following review and intervention involving the commissioners: "He is going back to his day service. The atmosphere appears to be getting better now". Another person's relative also told us a number of community based activities had recently been provided for the person.

The complaints system was unclear, lacked transparency and had been managed inconsistently. A relative told us that, beyond a year ago, they had emailed the registered manager about concerns and "He sorted them out. Then I was told not to contact him but somebody else, but these people kept changing". They expressed frustration at "The number of times I was told by the management they would call back or email but didn't". Relatives did not feel their concerns were always listened to by the provider or registered manager.

There was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Management systems were not in place to provide on-going assurance of the quality and safety of the service. At the time of the inspection the registered manager was absent from the service and there were interim management arrangements in place. This person had been made the line manager for three services and had no previous management experience or qualifications.

There was no evidence of quality assurance forming part of the management or development of the home. The home manager told us that quality assurance visits including spot checks had previously taken place and reports of these were produced with action points. However, records of these were not available in the home and we were unable to obtain them from the provider. It was not possible to assess how any actions identified as necessary were followed up and completed. There were some paper records of monthly audits up until June 2016 and we were told the system was now on computer. Where audits had taken place, such as with the audit for the controlled drugs book, this was ineffective and contained errors. A new system was being introduced and did not yet have everything uploaded onto it. Although the provider had begun to identify some concerns, the lack of information available and the confusion around systems meant the provider and CQC could not be assured of the robustness of the audits.

The provider had failed to keep staff informed about who managed the home. Staff were unclear as to the structure of the organisation they worked for. This meant they were unable to access appropriate support if they were concerned about how the home was run. There had been a lack of oversight and monitoring of the service and staff did not know about the board of directors, who they were or what their role was. The directors appeared not to have known what was happening in the service. Interim management later informed us that meetings with staff were to be held to clarify this and other policies, processes and systems.

The incident reporting system was not robust. We looked at the available incident records going back to June 2016. There had been approximately 12 incidents in that time. There was a new process put in place since November 2016 which improved the recording of incidents. However the interim manager agreed that there was still inconsistency with following up incident reports to demonstrate what had been learned; and reviews of care from arising incidents was not clearly documented. Feedback from incidents to the home from the registered manager and executive team at head office did not regularly occur and staff felt frustrated by this.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incident reports were now being sent directly to the interim manager and were used to inform support planning. We saw incident report summaries from 14 February 2017, completed by the interim manager, that showed trends were being analysed and risk assessments updated accordingly.

There were insufficient systems in place to ensure that the registered persons were aware of the need to

notify the Care Quality Commission (CQC) of significant events in line with the requirements of registration. We had not received any notifications within the last 12 months. During the inspection we were aware that the police had been called to the service, the registered manager was absent with alternative management arrangements in place and there were on-going safeguarding investigations. None of these events had been notified to CQC. The lack of consistent incident reporting meant it was not possible to robustly assess events that would require notification.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There were two systems of handover in operation. The home manager told us the on call person at head office phoned the home at 7am, 5pm and 10pm and went through a checklist with staff, which was recorded at the head office. This was a series of questions mostly requiring yes/no answers such as 'do you have enough personal protective equipment such as gloves.' Records of this were not available. Staff also gave a verbal hand over to other staff when shifts changed.

A shift leader checklist and allocation record showed roles and responsibilities were assigned by a senior staff member to staff on shift, such as medicines and security checks. Not all allocation records were on file or complete. There was no audit trail to ensure people were supported or that actions were done correctly. There was no evidence of how this was monitored by the registered manager.

The registered manager had not promoted a positive, open and inclusive culture at the service. There had been a lack of support and development of staff and staff did not feel included or empowered to contribute towards the service. There had been a lack of communication. A relative said the registered manager had denied access to the person's social worker at one review. Another relative said the management had been "more focused on money rather than people".

The registered manager "Took almost the whole management team to Zimbabwe, leaving a skeleton staff". They said "I got the feeling staff were not well treated". They mentioned "One member of staff was denied a holiday with their family as they were told they couldn't be spared. This was about the same time as the management team went away".

Another relative said there had been "Administration issues. There have been times when communication has not been as good as I would like". However "The key element is how happy is (the person)". They were "Aware of a big rumpus going on regarding the head office. It doesn't seem to have affected (the person)". There had been a lot of staff changes as staff "didn't get the backup from management".

Communication was ineffective and had led to a service which was not managed. Staff were unsure about what was happening in the service. During the first day of the unannounced inspection the service was chaotic and disorganised. Staff turned up for a meeting that had been postponed but they had not been informed. The manager on call system was ineffective and staff were unable to contact the appropriate person for advice. Another member of staff had come in for training but staff were not sure where or when this was now taking place.

Staff were uncertain about which systems they were supposed to be using either paper or electronic. A senior member of staff told us this was to have been discussed at the meeting.

The registered manager had introduced new technology but this had not been used in a way that enhanced the delivery of effective care and had not supported good outcomes. The systems in place had not promoted open, transparent, communication between management, staff, relatives and community

professionals. This had lead to a lack of clarity to staff in relation to their roles and a lack of trust amongst staff and managers within the home.

There were some concerns noted in the minutes of an interim management meeting as to who had access to what systems currently and the fact that the registered manager held the key to the website and giving or taking away email addresses for all staff. It had been discovered that staff did not have access to incident and complaints forms on the system and no one present at the meeting had any knowledge about how this had happened.

Staff told us that since 2014 there had been a number of people appointed to manage the home on a daily basis, which caused confusion for staff about who to go to or call for support and advice. A senior worker had taken the role but was not given a job description or support so stepped down again. Staff told us there was a period when another person had overseen the home but did not visit.

The current home manager had been in post since November 2016 but had not received a job description or any confirmation of the parameters of the role, despite raising this during their supervision meeting, with the registered manager or delegated person, which they had to insist took place. Support had not been made available and the home manager had felt disempowered in trying to fulfil their role. They told us they had been given "Responsibility but not the authority". Changes had been taking place during the last two weeks and the home manager said they felt they and other senior staff were now being listened to. The home manager demonstrated a clear sense of purpose in working to promote people's health, safety and quality of life.

The home manager said staff had been told things would happen that did not, so there was an issue of trust. A member of staff had been informed that morning of management changes and told us "Things are moving in the right direction". The home manager was also "Hopeful about what is happening now".

There were no records of staff and management meetings after June/July 2016 and the home manager confirmed there had been no meetings. Following the inspection the interim manager sent us the minutes of two meetings that had been held following the start of our inspection on 24 February and 1 March 2017. These records showed that actions were being discussed and taken in relation to staff DBS checks, records, induction and training, job descriptions, the on call system, rotas and shift planning, IT systems, handovers and care notes, complaints and staff disciplinary policies and procedures, staff meetings and supervision, and meetings with parents. Multi disciplinary team meetings were taking place to discuss matters relating to each person using the providers services.

The home manager confirmed a staff meeting was scheduled for 2 March 2017 in order to revisit policies and staff guidelines, including smoking and the use of mobile phones.

The board of directors informed us the senior executive function was being reviewed under the guidance of consultants. An appropriately qualified manager had been appointed in the interim period until a long term manager could be recruited.

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 not notified the commission of significant events. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not received person-centred care that was appropriate to their needs and reflected their personal preferences, including assessment reviews to ensure that people's goals or plans were being met and were still relevant. Regulation 9 (1) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints A clear, consistent and effective complaints system had not been established and operated. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance systems in place to monitor the safety and quality of the service. Regulation 17 (1) (2) (a) (b) The provider had not maintained accurate,

complete records in respect of each service user. Regulation 17 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures to ensure that persons employed are of good character had not been established and operated effectively. Regulation 19 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitable qualified, competent, skilled and experienced persons were not deployed at all times. The approach used to determine the number of staff and range of skills required in order to meet people's needs and keep them safe was not effective. Regulation 18 (1) People were not cared for and supported by staff who all had appropriate support, training, supervision and appraisal to enable them to fulfil the requirements of their role. Regulation 18 (2) (a)