Huntercombe Homes (Ilkeston) Limited

Nottingham Neurodisability Service - Aspley

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 25 September. Nottingham Neurodisability Service – Aspley is a purpose built unit providing health and personal care for up to 32 adults, on the day of our visit 25 people were using the service

When we last inspected the service in November 2016, we found multiple breaches of the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated as requires improvement and we asked the provider to make improvements to meet the legal regulations. During this inspection we found that some of the required improvements had been made, but further improvements were still required, this resulted in us finding some on-going breaches of the Health and Social Care Act 2008 Regulations (2014). We also found further concerns which led to a further breach of the regulation. You can see what action we told the provider to take at the back of the full version of the report.

The service did not have a registered manager in place at the time of our visit. The registered manager had recently left the service and the present service manager told us they were going to apply to become the registered manager in the near future.

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 risks to people's safety were not always assessed robustly and information in the risk assessment was inconsistent. Staff did not always follow the information in people's risk assessments to ensure safe care.

People were at risk of exposure of abuse and neglect as the measures in place to protect them were not always robust and recommendations were not always followed by staff.

The management of medicines was not always safe as staff did not follow guidance in place around safe practices. When monitoring safe storage of medicines staff had not raised with the management team when they found areas of concern. There was a lack of auditing of medicines and some protocols for people who required medicines on an 'as and when required' basis, did not give staff the information required to safely administer these medicines

The principles of the Mental Capacity Act 2005 were not always followed. People were not supported to make decisions for themselves and it was not clear that decisions made on their behalf had been done so in their best interests.

Staff were supported with adequate training for their roles and a sufficient number of staff were employed to care for people.

Majority of people were supported with their nutritional needs but there were occasions when the lack of staff knowledge in relation to people's diets, put them at risk of receiving foods that were not appropriate for them.

People's health needs were not always well managed as staff did not always follow instructions from health professionals to assist them to manage these.

People were not always treated with respect and at times the cultural needs of people were not always met. People's privacy was maintained but they were not always supported to maintain their dignity.

People did not always receive individualised care as the information in their care plans was not consistent and staff caring for them did not always have the knowledge of their needs.

The service offered a range of social activities for people but some people told us the activities on offer did not always meet their needs.

People felt able to raise complaints and concerns to staff and the service manager and felt they would be responded to. The service displayed a complaints policy in a format that people could understand.

The provider had continued to fail to report significant events that occurred to enable us to monitor the service.

There were a lack of robust auditing systems in place to monitor the quality of the service and this significantly contributed to the on-going breaches of regulations found at the service.

There was a lack of structured support and supervision for staff who worked at the service

People and staff told us the management team were approachable and people who lived at the service had some opportunity to give their views on how the service was run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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 provider's found to have been providing inadequate care should have made significant improvements within this timeframe.

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

The risks to people's safety were not always assessed and staff did not always follow information in people's risk assessment to keep them safe.
Medicines were not always managed safely and people were at risk of receiving medicines inappropriately.

People had been exposed to abuse and the on-going measures to manage this were not always in place.

Staffing levels had been increased to meet the needs of people in the service

Is the service effective?

Requires Improvement

The service was not always effective

The principles of the Mental Capacity Act were not always followed and people did not always receive the support they required to assist them with their decisions.

Staff received training to support them in their roles

The majority of people received support to manage their nutritional needs but there were occasions when staff lacked the knowledge to ensure the diet people received was safe.

People's health needs were not always managed well and there were occasions when instructions given by health professionals had not been followed by staff.

Is the service caring?

Requires Improvement

The service was not always caring

People told us they were not always treated with respect

Some people's cultural needs were not always met.

People's privacy was maintained but people were not always supported with their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always receive individualised care as the information in their care plans was not always consistent and staff did not always know people's individual care needs.

There were a number of activities on offer for people but these did not always meet the social needs of people and there was a lack of stimulation for a number of people at the service

People felt able to complain to staff if they had any problems and the complaints policy was visible in the service in a format people could understand.

Is the service well-led?

Inadequate

The service was not well led

There was no registered manager in place at the service.

The provider had continued to fail to report significant events to enable us to monitor the service.

There were a lack of robust systems in place to monitor the quality and safety of the service and this contributed to the on-going breaches of regulations found.

There was a lack of structured support for staff who worked at the service.

Nottingham Neurodisability Service - Aspley

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.

This inspection took place on 25 September 2017 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who had personal experience of using or caring for someone who uses this type of care service.

Prior to our inspections we reviewed information we held about the service. These included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to end us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service.

During the visit we spoke with nine people who used the service. We spoke with three registered nurses, five members of the support staff, and activities co-ordinator, the cook and the service manager. We looked at the records of seven people who used the service, medicine records, staff training records, as well as a range of records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

When we previously visited the service in November 2016 we found the information in people's risk assessments were not always implemented and did not always reflect the care being provided for people. This meant people did not always receive the care they required to maintain their safety and the provider was in breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) regulation 2014.

At this visit we found the provider was still in breach of this regulation. Some of the care records we viewed lacked some risk assessments to provide essential information for staff to provide safe care. Other risk assessments that were in place in people's records were not always up to date. This impacted on the safety of people who lived at the service.

For example, the care plan for one person was not up to date with their current needs. Throughout the care plan for the person there were references to a bed rail being in place on one side of their bed. However, we asked staff about the bed rail and they told us the person did not have a bed rail. They took us to the person's bedroom and checked the bed and confirmed there was no bed rail. In the same person's 'safe environment' care plan, it was recorded that they must wear a lap belt when seated in their wheelchair due to a risk of falling from the chair. The service manager told us the person did not use a lap belt and we saw the person in their wheelchair throughout the day and there was not a lap belt in place. The manager confirmed following the inspection that the lap belt should have been in place due to the risk of the person falling from the chair. A lack of knowledge of this person in relation to the lap belt and a lack of up to date information about the bed rail posed a risk of the person receiving inconsistent care and support.

There was also information in this person's care plan detailing that they required a hoist for all transfers. However, there was not a moving and handling plan in place detailing which sling/ straps staff would need to use to transfer the person safely. This meant staff did not have the information needed to support the person to transfer safely.

Information in another person's care record related to the person's risk of choking and stated the person should be observed when eating to identify signs of choking such as coughing and assist the person accordingly. On the day of inspection we saw that staff were not observing the person when they were eating. The person ate alone in their room without supervision and all staff we spoke with told us the person did not require supervision. The practice of staff not adhering to the information in the care plan meant they would not be in place to support the person should they choke whilst eating and placed the person at risk of serious harm.

The same person had information in their care plan that stated two members of staff should support the person when they received personal care. This was due to the person's behaviour patterns. However, there was not a risk assessment in place in relation to support staff of how to meet this need. Staff we spoke with gave conflicting answers in relation to their practice when offering personal care to the person. Three members of staff told us they sometimes provided care alone and only one member of staff stated the person always required two members of staff to support them. This inconsistency of staff practice showed

they were not using the information that was provided to maintain both the person and their own safety when supporting the person.

When we previously visited the service in November 2016 we found the medicines systems were not always safe. At this inspection we found further issues in relation to the safety of medicines at the service.

There had been a recent audit by the local clinical commissioning group (CCG) medicines team on the 12 July 2017. The recommendations made by the medicines team had not been acted on and people were still being placed at risk of poor practices in relation to medicines.

For example, it had been highlighted by the CCG team that the medicines trolley when not in use should be secured to the wall in the clinical room. When we first visited the room both medicines trolleys were not secured to the wall as required.

We found the daily temperature recording for the medicines fridge and clinical room were undertaken, but over the previous two months the temperature recordings showed that at some point in each day, the temperature had been recorded 11 degrees, which is higher than the accepted level by three degrees. This had not been highlighted by staff recording the temperature to senior staff and meant the medicines kept in this fridge could be compromised. On the day of our inspection there were prescribed creams stored in the fridge that should have been stored at temperatures not exceeding eight degrees. The lack of medicines audits being carried out meant any errors or discrepancies in relation to safe handling of medicines were not identified and acted upon by the management team.

For example, one person had been prescribed a strong pain killer to be taken by mouth on an 'as and when required' basis but their MAR (Medicine Administration Record) also showed they were prescribed this strong pain killer as an injection. There was not a protocol in place to guide staff on when and why the oral medicine should be given. A member of staff told us the medicine to be given by injection had been prescribed temporarily when the person had been ill and could not manage oral medicines. The member of staff told us this injection was not being given and should staff feel it was required, they were meant to contact the person's GP. This information was not reflected in the MAR and placed the person at risk of receiving an over dose of this medicine.

We examined further medicines records in place and found there were a number of these records which also lacked a clear protocol for the use of 'as and when required' medicines so as to give staff guidance on when, how and why the medicines should be given.

People we spoke with gave mixed views in relation to receiving their medicines when they were supposed to. A number of people told us they received their medicines when they were meant to but one person we spoke with told us, "Sometimes they (staff) forget, I have to remind them." Another person told us they usually got their night time medicines between 9 and 10pm but sometimes staff were late bringing it, the person said, "I think it is because they are so busy."

The above issues showed the provider was continuing to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the service were not always safe from abuse. One person we spoke with told us although they felt safe most of the time, there had been an incident with another person who lived at the service which had made them feel very unsafe. They told us they had reported this a number of months ago and the previous unit manager had not addressed it. However, the present service manager had acted upon

the person's concerns. The service manager arranged for the person to have a lock on their bedroom door so when they were in there they felt safer.

We looked the care plan of a person who had an allegation of abuse made against them and it was recorded that the person should be observed at all times when in the company of others. However, it was evident from discussions with staff that this was not being adhered to and there were no regular or formal observations in place. A senior member of staff told us, "Staff don't have specific eyes on [name] – [name] usually chooses to spend time in (their) room with the door open or will sit in the corridor." There was a lack of care plans aimed at informing staff of the potential risk of this person to other people who used the service and to minimise the risk of harm. This placed people at the service at risk of harm and did not support the person who required observation and support to manage their behaviour patterns.

During our inspection we found that safeguarding incidents had not always been raised and investigated appropriately. For example, on two separate occasions in one month one person been found with their urinary catheter not in place. The nurses checking the person's records on each occasion showed that the catheter had not been in place for between three and five days. On one occasion the person had become irritable and confused and when the catheter was reinserted 400mls of fluid was drained, meaning the person may have been in discomfort or pain. On the second occasion the nurse had noted there was bloating and distension of the person's abdomen prior to reinsertion of their catheter. This was a potential act of neglect in the management of this person's needs and had a negative impact on their care. Additionally this was not referred to the safeguarding team or investigated by the service.

We also found that safeguarding investigation recommendations were not being followed by the service. For example, there had been two recent safeguarding investigations for a person in relation to a failure to assess and plan for epilepsy. Staff had called 999 in March 2017 when the person had a seizure and needed to attend the hospital. We found that despite this the care plan for epilepsy was still inaccurate and did not inform staff how to support the person if they had a seizure. The epilepsy care plan stated that the person was not prescribed any emergency rescue medicines for epilepsy, however there was a medicines care plan in place which stated a rescue medicine was prescribed to be given as required if the person had a seizure. We checked the medicines administration chart for the person and this medicine was not recorded on the chart, however there was stock of the medicine for the person at the service. This posed a risk that staff would not administer the rescue medicines if the person had a seizure.

Additionally the care plan contained only brief details stating that if the person had a seizure lasting for more than five minutes to call 999 for an ambulance. There was no detail about how to keep the person safe whilst having a seizure or what to do if the person had more than one seizure. This showed a lack of response by the provider to safeguarding concerns raised and placed the people who lived at the service at significant risk of harm through neglect.

The above issues show the provider is in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with at the service gave mixed feedback in relation to the staffing levels at the service. One person told us they sometimes had to press their buzzer a number of times and could sometimes wait half an hour before a member of staff came. Another person also told us they could wait between ten minutes and an hour before a member of staff came to assist them. However other people we spoke with told us they did not have to wait very long for staff to assist them.

Staff we spoke with felt that staffing levels had increased recently and this had improved their ability to meet

people's needs. A senior member of staff told us there were a large number of people who lived in the service who required two members of staff to assist them with their care and the increased staffing had 'helped with this'. Another member of staff told us they previously had little time to spend with people but, 'can spend time talking with people now.' A further member of staff told us the increased numbers of care staff had meant staffing was 'alright now'.

During our inspection we saw there were adequate numbers of staff on duty. We discussed how staffing levels were managed with the service manager who told us there had been an increase in registered nurses on the day shift and two registered nurses now worked during the day and one registered night at night. The service had been working to recruit more registered nurses as they were reliant on agency nurses to cover a large number of shifts as they had a 20% shortfall in the established requirements for registered nurses.

The service manager told us they used a particular agency to supply them with nurses and 'block booked' individual nurses to provide continuity of care for the people who lived at the service. The service manager told us their recruitment processes were on-going and they wished to build a strong team at the service. They had recently employed two new nurses who were presently being inducted to the service.

We looked at the service's recruitment processes and found that majority of staff files contained relevant information to show safe recruitment practice had been followed. There were relevant references from past employers and registered nurses had up to date proof of registration with their regulatory body. The service used the Disclosure and Barring service (DBS) to check if staff had any previous criminal convictions that would mean they were not safe to provide care for the people at the service. We found one person who had worked for the service for some time had required their DBS check to be renewed. This had not been undertaken and we addressed this with the service manager who gave us information prior to us leaving the service on how they were dealing with this issue as a priority.

Requires Improvement

Is the service effective?

Our findings

When we previously visited the service in November 2016 we found the principles of the Mental Capacity Act 2005 (MCA) were not being applied consistently to ensure people's rights were protected. This was a breach of Regulation 11 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 as far as possible people make their own decisions and are helped to do to 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. We found the service was still not working within the principles of the MCA.

At this inspection we found the MCA was not consistently applied. For example, records showed that one person had fluctuating capacity and lacked the capacity to make some decisions. Records showed the person had been assessed as being able to make a decision about whether bed rails were an appropriate safety measure. However, there was a consent form for photography in the person's care plan which had been signed by the person's friend which indicated the person lacked capacity to make this decision. There was no MCA assessment to show whether the person had the capacity to decide this for themselves and there was no evidence the person's friend had the legal authority to make decisions on their behalf. Another person who had been assessed as being at high risk of falls had a care plan in place detailing they had a history of falls in their bedroom due to mobilising alone. The plan stated this had been discussed with the person and that they had decided they would continue to transfer independently without assistance from staff. This person had an acquired brain injury and so may not understand the risks of falling and sustaining an injury. A mental capacity assessment had not been undertaken to assess if the person had the capacity to understand this decision and the risks to their safety.

A further person's care records stated they were unable to manage their finances and had passed the responsibility to a relative. The person's pre admission assessment stated they had capacity when they were admitted to the service a number of years previously (2006), but there had been no mental capacity assessment undertaken recently to show if the person had the capacity to make this decision.

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 the authorisation of a DoLS for one person and found the conditions of the authorisation were not being met. One recommendation was for the service to contact the dementia outreach team for support for the person. We checked the person's records and could not find any evidence of this taking place since the authorisation had been made. A further condition of the DoLS was for the service to make continued efforts to offer trips out and walks in the grounds of the service. The condition stated the service should document what had been offered and the person's responses documented in their care plan. We viewed the person's care plan which had been written following the authorisation of the DoLs and this did not incorporate the conditions of the DoLS.

The above issues show the provider is in continued breach of Regulation 11 of the Health and Social Care Act 2018 (Regulation Activities) Regulations 2014.

Most people we spoke with told us they felt staff were trained to support them with their needs. One person told us, "Staff are having more training at the moment, new developments in caring, they need to keep up."

Staff we spoke with told us there was more structure and training in the service. One member of staff told us, "Training is a big improvement and has had a positive impact on people (staff)." The member of staff gave the example of receiving training in an area to support people with a long term health condition with particular medicines. They went on to tell us they had also received training in particular health conditions such as diabetes and epilepsy. Another member of staff told us they had recently received some mandatory updated training sessions in areas such as moving and handling, health and safety, MCA and DoLS. We also spoke with a new member of staff who told us they had received a supportive induction when they commenced employment at the service

The service manager told us staff were encouraged to undertake on line training when they were on duty and the increased staff levels had supported this. The service manager told us that all e-learning staff had undertaken was recorded onto a computerised system that then contributed to the reports on the training matrix. This had given them more confidence that staff were receiving the required training for their roles.

People we spoke with felt they got enough to eat and drink and told us there was a choice of foods at each meal. One person told us they got 'More than I can manage.' We asked people if they were offered snacks and drinks one person said, "Yes they are everywhere if you want them."

During our visit we saw that majority of people were supported to eat and drink safely and staff had a good understanding of the different needs of people who required their support. However, we saw in one person's records they had previously been assessed as needing a 'soft diet' due to a choking risk. The person had been refusing meals and a re-assessment had been carried out by the provider's speech and language therapist. There was a new care plan in place stating that the person could have a normal diet but with restrictions on certain types of foods that could be a choke risk. We asked staff, who supported the person if there were any restrictions of their food and a number of staff who provided their care told us there were none as far as they were aware. However, one member of care staff we spoke with was aware of the restriction. The lack of knowledge of the restriction by majority of the staff we spoke with meant the person was at risk of receiving foods that could increase the risk of choking.

Staff we spoke with felt they were provided with information about people's health care conditions and that the registered nurses responded quickly to any health care issues raised to them. However we saw evidence of some instructions from a health professional had not been carried out. One person's care plan showed the health professional had asked for a twice daily test for one person's long term health condition to be carried out by staff for a period of two weeks. Staff were meant to record the results of the tests to allow the health professional to review the person's condition to manage their on-going care. We found the checks had not been carried out consistently by staff. The recordings had been entered on two different charts and there were gaps to show the checks had either not taken place or had not been recorded by staff. This meant the health professional would not have the information they required to assist them with the person's on-going care and this could impact on the person's long term condition.

Requires Improvement

Is the service caring?

Our findings

Some people we spoke with told us they were not always treated in a caring way. One person told us staff could be rude to them. Another person felt staff did not always understand the problems they had with communication and this impacted on the way staff spoke to them. However, other people we spoke with told us staff were caring and knew them well. One person told us, "I wanted to do my Christmas shopping I let them (staff) know and they planned it for the week after, stopped me worrying about it." Another person told us that staff helped them use the internet to support them to interact with their family. A third person told us if they needed anything staff would do it for them. They went on to say that a member of staff had gone to the shop for them in their own time when they needed something.

Throughout our visit whilst we saw staff were busy, their interactions with people were positive. We saw they were talking with people in a way that indicated they knew them well. For example, two people were very distressed due to the lift breaking down for a short period during our visit, and their inability to reach the ground floor of the service. We observed staff stayed with these two people until the lift was repaired, offering reassurance and information about what was happening. One member of staff sat with one of the people, who had become anxious and angry, and showed them pictures and told them stories of what they had been up to with their family. This resulted in the person becoming calm and laughing with the member of staff.

We discussed people's needs and preferences with staff and whilst they showed good knowledge of the needs of some people, we found staff knowledge of people's needs was not always consistent. Such as their knowledge of restrictions of people's diets or the level of observations staff should maintain for individuals. This meant people were not always receiving care in the way they needed it.

People we spoke with told they had not been involved in the development and reviews of their care plans, as much as they wanted to be. One person said, "I do not get involved, don't want to do anything wrong, (I) let them (staff) do the paperwork. I let them know if I have a problem." Another person told us, "I talk as we go along rather than being involved in a review." A third person said, "I have done in the past, (been involved with their care plan) for hoisting into my chair."

Whilst we saw some evidence that some people or their relatives had been involved with reviews of care plans, this was not consistent. For example, one person's care plan had a record of a review carried out in 2012 and the person had declined to attend the review. We could not find any further evidence of care plan reviews for the person. Which meant the person and their relatives had not been given further opportunities to review and comment on the care the person received.

We saw there were occasions when people's cultural needs were not always met. We viewed the care plan for one person who had been visited by an external professional in March 2017. The professional had recorded in the person's notes that they identified with a specific culture and that staff should identify links in the Nottingham area. The person's care plan had not been updated to reflect this recommendation and records did not reflect the links had been established.

However, one person had expressed a desire to wear clothing of the opposite gender. We saw there was a care plan in place which detailed how the person could be supported to achieve this and a member of staff had supported the person to shop for the clothing.

We also saw one person who required restrictions on their diet due to their cultural beliefs and this had been accommodated by the service. The service also had information for people on advocacy services. An advocate is a trained professional who supports, enables and empowers people to speak up. The service had engaged the services of an advocate for people in the service who required this support.

Majority of the people we spoke with felt their privacy and dignity was respected by staff. One person said, "Yes, they (staff) knock on my door." And another person said, "Carers are respectful." However, one person told us they felt staff did not treat them with respect.

Staff we spoke with were aware of their roles in maintaining people's privacy and dignity and were able to give examples how they achieved this. We saw the dignity values people should expect from the service were on display for staff and people. We spoke with the service manager about how they were managing the privacy and dignity of people. They explained they had undertaken a lot of work with staff since being in post. Highlighting to staff that this was people's home. They had spoken to people about privacy and dignity issues and people had raised that staff had not been knocking on their door before entering. The service manager had raised this at a staff meeting and addressed the issue so improvements in this area had been made.

Requires Improvement

Is the service responsive?

Our findings

When we previously visited the service in November 2016 we found the information in people's care plans did not always reflect the individual needs of the people who lived at the service. This meant people did not always receive the individualised care they required to maintain their safety and the provider was in breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) regulation 2014.

At this visit whilst the people we spoke with told us they received individualised care we found evidence to show this was not always the case. We viewed care plans that did not contain sufficient information for staff to provide people with individualised care. For example, one person had a tissue viability plan in place and it was recorded that the person had chronic leg ulcers. Despite this there was no plan in place detailing how the person's chronic leg ulcers were managed in relation to how often they were dressed and what should be used. There was also a
lack of information on how the person's pain in relation to their leg ulcers was managed.

Another person had a care plan in place for a long term health condition. The plan contained only brief detail about the person's condition and did not give staff information on how to manage the condition when the person health became unstable. There was a lack of information for staff to support this person if the condition deteriorated.

There was a lack of consistency in the range of care plans in place for people. For example, people who displayed particular behaviour patterns that impacted on other people, did not always have care plans in place regarding cognition, behaviour or psychological needs. This meant staff did not always have guidance on how to manage people's behaviours.

One person's care record stated that ABC charts be used to document behaviours. An ABC chart is a way of staff recording what events lead up to a particular type of behaviour, what the behaviour was and what the consequence of the behaviour was. We were unable to find the ABC charts, however a senior member of staff told us they should be used. We spoke with another member of staff who was unaware that ABC charts were being used to monitor the behaviours of some people at the service.

Staff we spoke with felt that communication at the service was improving. A registered nurse told us there was a handover sheet used each day, this showed any major issues that had occurred during the shift and all registered nurses were meant to read and sign the sheet to show they had read the information. We also saw there was a communication book for staff to pass on information. Staff told us they did get to read the care plans and the service manager attended a handover every day when they were on duty. However, our observation of issues we found and discussions with staff showed that there were areas where communication around people's care needs could be improved. For example, our discussions with staff on the monitoring of one person showed they were not aware of a safeguarding investigation outcome that recommended the person have one to one care.

Whilst the service employed two activities co-ordinators and had a range of activities on offer some people

we spoke with felt the range of activities was not broad enough and did not interest them. One person said, "If I go to activities I can't sit down for long as it becomes painful. I have to go back to my room and lay down, so I don't get involved in activities." Another person said, "I watch TV most of the time, activities offered are not my thing so I watch TV every day, boring life."
A third person told us they enjoyed the music when the musicians came in to the service. A further person told us they enjoyed colouring pictures, card making and reading.

On the day of our visit we saw a card game was being played in the activity room between five people. Staff told us they concentrated on mental stimulation activities for people however, we saw people were sitting for long periods of time with little stimulation.

People told us they felt able to raise complaints or concerns to the staff at the service. One person said, "I would have a word with the nurse or the manager. If it is personal I would speak to the manager in their office or my bedroom." Another person told us they had raised a complaint in the past and it had been dealt with to their satisfaction.

Staff we spoke with told us they knew how to deal with any concerns raised to them. A registered nurse we spoke with told they would try to deal with any issues raised to them and would record their actions. They told us if they were unable to deal with the complaint they would record it and pass it on to the service manager to deal with. Staff we spoke with felt confident the service manager would respond to complaints raised to them

We saw there was a complaints procedure on display, which was written in a format people who used the service would understand.

Inadequate

Is the service well-led?

Our findings

When we previously visited the service in November 2016 we had concerns about the lack of governance in the service as the provider had not taken steps to ensure there was an effective system in place to monitor and assess the quality of the service to ensure issues were identified and necessary improvements made. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection we found the provider had not fully addressed this and we found additional concerns in relation to the governance of the service. The service manager had been in post for approximately eight weeks and told us they had been 'crisis managing' since starting. They had been supported by the regional manager and together they been addressing issues such as staffing levels, staff training and safeguarding issues. However, we found a number of significant issues that showed there was still a lack of oversight of the quality of the care provided at the service.

The service manager told us they had not completed any quality assurance audits since coming into post and were unable to produce any internal audits prior to them working in service. The provider had commissioned a Boots medicines management audit 23 May 21 June 2017. The results from this were fed into their Quality Improvement plan that was subsequently implemented. However at our inspection we still found issues with medicines management and found no evidence that any auditing processes had been implemented that would have addressed these issues.
This lack of effective quality auditing extended to the senior management team as there was a lack of robust over sight of the service. The provider told us they had undertaken a series of audits as part of their Quality Assurance Framework review in April 2017 and this information had been shared with us prior to the inspection as part of the provider's quality improvement plan. They also told us they had carried out peer to peer Huntercombe audits in July 2017 for risk assessments and care planning. However at our inspection we found a number of concerns with the information contained in care plans and risk assessments that had not been identified at these audits This meant the issues raised at the last inspection around the lack of robust quality audits had not been addressed. The continued lack of effective audits meant there continued to be no robust system in place to monitor and assess the quality of the service to ensure issues were identified and necessary improvements made.

There was a continued lack of robust medicines audit system in place and this had resulted in issues around safe management of medicines. This was despite the CCG medicine audit undertaken in July 2017 making a number of clear recommendations to the service on managing their medicines safely. The lack of audits of the care plans had resulted in a lack of up to date and inconsistent information in relation to people's care.

The service manager told us all falls, incidents and accidents were recorded on their electronic reporting system known as datix which was the way the company records all adverse incidents. Following our visit we were sent copies of the information that had been inputted on the datix system. There were a number incidents that showed whilst they were being reported onto the system, the system was not used as it was intended. This was to give an over view of the significant issues at the service to allow the senior

management team to analyse, act and to learn from past events. This put people at risk of repeated poor care.

For example, it had been reported on the datix system that staff had failed to notice a person's catheter had come out. This was re-inserted by the nurse after a few days. There was no investigation into this, nor action taken to minimise the risk of this happening again. Records showed this happened to the person again not long after the first incident and again staff failed to notice the catheter was not in place. This showed that the datix system had not been used to identify learning from this.

When we previously visited the service in November 2016 we found an incident had occurred a year prior to that visit in which a person had become trapped in the bed rail in place on their bed. A root cause analysis (RCA) had been undertaken at the time to identify lessons that could be learned. At the last inspection we found that some actions from the action plan developed had not been fully implemented. We followed up on this RCA at this visit with the service manager however they were unaware of the RCA, as it had not been passed on to them.

The clinical lead who was aware of the RCA discussed the progress with us and we found actions identified as not being completed at the last inspection, were still not implemented. The night staff were meant to undertake a nightly check of the bed rails however we found the check form did not show what should be checked it was simply a tick box which stated 'bed rail'. The records we were given showed that this check had only taken place10 out of 18 nights prior to our visit, with no rationale as to why it was not completed every night. The clinical lead told us they had developed a form which showed what the staff should check each night but this was not in use yet. This showed the provider had continually failed to respond to significant issues of concern and continued to place people at risk of harm through poor auditing processes

The above issues show a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

When we last visited the service we found they were in breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009 as they were failing to notify us of significant events that had taken place at the service.

During this visit we found a number of incidents that had been recorded on the provider's datix system that should have been reported to both ourselves and the local safeguarding team, and the registered provider had not done so.

For example, a datix incident form showed that in June 2017 there had been a water flood in the laundry which had come from a boiler. Staff had recorded that this boiler was broken and could not be used until the following week when it was replaced. In the meantime, staff were to use hot water in a limited way, and were not to use large amount of hot water at the same time such as two showers at once. As this was a disruption of the service we should have been notified of this issue by statutory notification and we were not notified of this.

A further datix incident record showed that one person had a pressure sore to their finger which had been caused by their finger nail pressing against it. The incident form showed that staff had noticed a bad smell from the person's hand and the wound looked infected. The tissue viability nurse advised this was a grade two to three ulcer and would require a CQC notification. This was not referred to safeguarding as a possible act of neglect and we were not notified.

Records we viewed at this visit also showed that a person had been granted a DoLS authorisation and we had not been informed of the authorisation.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009

At the time of the inspection there was not a registered manager in post. The service manager told us they were going to apply with the CQC to become registered but had not started the process. It is a legal requirement of the service to have a registered manager in post. The service manager told us they intended to apply in the near future.

People we spoke with told us the service manager was visible and approachable. One person said, "Yes often see them and they always say hello." Staff told us they felt the service manager and regional manager was approachable and spent time around the service. One member of staff said, "Good, approachable, they will listen and act up on problems."

Staff told us they felt confident to discuss any issues with the service manager and they were supported by the management team. The service manager told us although they had begun to undertake some supervisions these had been sporadic. They told us they had prioritised undertaking supervisions with key members of staff such as the head of housekeeping and the nurses. The service manager told us that they had no plan in place for the rest of the staff groups at present but was holding regular staff meetings that they have used as group supervisions. However, we asked to see the meeting minutes of staff meetings and were told the last meeting had taken place in July 2017 and the minutes had not yet been written up. This meant there was no evidence of on-going supervisions for the majority of the staff group.

The service manager also told us they were aware that clinical supervision had not been taking place for their registered nurses. It is requirement of a registered nurse to show they undertake regular reflective discussion of their practice and their employers are required to support this. The service manager recognised that it would not be appropriate for them to undertake this with the staff they line managed and had been looking into ways this could be provided for staff through the company.

People we spoke with told us there were ways for them to express their views on the running of the service as there were resident meetings. However, the last meeting that had taken place was July 2017 and the minutes had not been typed up which meant we were unable to see what issues were raised and what action had been taken by the service to address them.

Following our previous inspection, we noted the rating for that inspection was on display in the corridor of the service.