# CareTech Community Services Limited

# Radnor House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection was carried out on the 2 August 2017 and was announced at short notice on the day to ensure people were in. At the previous inspection of this service on 3 and 5 June 2015 we found there were no breaches of legal requirements.

Radnor House provides accommodation and personal care for up to six adults with a learning disability whose behaviour may challenge others. There were five men living at the home at the time of the inspection. The accommodation is over two floors and consists of four bedrooms and two semi-independent flats. People have access to a communal lounge/dining room and a quiet room. There is an enclosed garden to the rear of the home.

The home had a registered manager in post who was present on the day of our visit. 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.

Since the previous inspection the service had experienced a change of registered manager and a high turnover of staff. The registered manager had been in post for just over one year and was trying to build a new staff team and address identified shortfalls. Actions towards achieving these improvements had been slow. The provider had not ensured through quality monitoring checks and audits, that adequate progress was being made in a timely manner and improvements made sustained.

At inspection for the majority of the time the atmosphere in the home was calm and relaxed. People were seen to be comfortable around staff and sought them out. Staff engaged well with people but there were not enough staff to meet the demands made on staff time and to meet everyone's needs.

Some of the people who had complex needs were not adequately engaged in meaningful activity Observations showed them to be bored and sometimes restless. Some people were not funded for staff to provide dedicated one to one hours; staff could not, therefore give them the time and attention they needed. Care plans were person centred and people and relatives were consulted about their support needs, however, care records were not always updated. Staff did not always implement the distraction techniques in place for one person to de-escalate behaviours that were upsetting them and other people were affected by this.

A programme of ongoing staff recruitment was underway; staff records however, failed to contain evidence of the checks made in keeping with legislation requirements. Medicines were not well managed and there was a risk of errors occurring.

Risks were assessed but were not always reviewed and updated to ensure any changes had been taken

account of. Health and safety checks and routine tests and checks of equipment were not carried out in either sufficient depth or frequencies, to provide assurance that people were safe. People could be placed at risk from infection because cleaning and infection control practices were poor.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff had received training in this and two people were subject to DoLS authorisations. Other people were subject to restrictions and staff managed aspects of their daily care and support but they had not been referred for DoLS authorisations. The registered manager did not demonstrate a clear understanding of the criteria for making an application to ensure the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Staff said that they felt supported by the new registered manager and that they were bonding together better as a team and thought they supported each other. Frequencies of formal supervision and appraisal to inform staff development, and performance were however infrequent. Staff meetings were held and staff said that they felt able to express their views and felt listened to.

New staff received an induction into their role and all staff were provided with a range of mandatory and specialist training; this provided them with the right knowledge and skills. Epilepsy training for a night staff member who lone worked was an area for improvement; this was to ensure the staff member knew how to recognise and respond to seizures should they occur.

People's health and wellbeing was monitored by staff. People were supported to access health appointments and health professionals when needed. People were consulted about what they ate and drank but the siting of the pictorial menu to a more accessible location for people is an area for improvement. Staff understood how to identify abuse in all its forms and respond and report their concerns to keep people safe. Staff understood how to respond and report incidents and accidents so people were provided with the right support, these were analysed for trends or patterns so measures could be implemented to reduce recurrence where possible.

People new to the service were assessed prior to admission to ensure their needs could be met. The majority of staff support was provided in a way that upheld people's dignity. Most people were unable to use the complaints procedure; staff understood how they expressed their sadness and unhappiness and would look for the causes of this. There was a need to ensure that all parties understood when a complaint was resolved and is an area for improvement. Staff respected people's privacy and supported them to maintain links with the important people in their lives.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of this report.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe

Medicines were not managed well. There were not enough staff to meet everyone's needs. A robust staff recruitment process could not be evidence from staff records.

Checks and tests of equipment were not sustained. Assessed risks were not kept updated. The cleanliness of the premises needed improvement and infection control audits were not completed. Health and safety checks were not comprehensive.

Staff understood safeguarding procedures and how to respond to incidents of abuse.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective

Staff felt supported but frequencies of formal supervisions and appraisal to inform their development, training and work performance were infrequent.

Staff received training in the Mental Capacity Act 2005 and DoLS but lacked understanding about how restrictive practices needed to be authorised.

People's health and wellbeing was supported appropriately by staff. People were consulted about what they wanted to eat.

Staff received induction and training to provide them with the necessary skills to undertake their support role.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring

People's privacy was respected but dignity could be compromised by staff not taking action to ensure peoples personal hygiene was upheld

Staff showed they knew people well and communicated with

them in the way they preferred.

People were supported to maintain links with their families and people who were important to them.

## Is the service responsive?

**Requires Improvement**

The service was not responsive

Some people did not have enough to do. Care plans were not kept updated and keyworker meetings to inform care plan updates were infrequent.

An easy read complaints procedure was in place but complaints were not always recorded in the complaints log or confirmation they were resolved.

New people were assessed prior to admission to ensure their needs could be met.

## Is the service well-led?

**Requires Improvement**

The service was not well led

The registered manager did not have clear oversight of what was working well and not working well, systems for assessment and auditing quality required improvement.

Relatives and people were asked for their views but new systems to capture views were delayed.

Staff meetings were held and staff said they found the registered manager approachable.

# Radnor House

**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.

This inspection took place on the 2 August 2017. This is a small service and we gave short notice of our visit on the day to ensure staff were available to give us access to the premises and documentation. The inspection was conducted by one inspector.

Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we met all the people in the service but were only able to speak with two as some people were not able to express their views clearly due to their limited communication. We observed interactions between staff and people.

We inspected the environment, including the communal and quiet lounges and dining area, the laundry, bathrooms, medicines room and some people's bedrooms.

We looked at a variety of documents including three people's support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, training records, medicine administration records, and quality assurance information.

At inspection we gave a poster to the registered manager to display in the entrance area inviting feedback from people, relatives and visitors.

After the inspection we contacted five relatives, three care managers and two health professionals for

feedback.

Inadequate

# Is the service safe?

## Our findings

People had communication difficulties and were unable to tell us about their experiences. We observed however, that they were happy and in positive moods for most of the inspection. They were comfortable in the presence of staff and sought them out when they wanted to show them something or communicate a need or wish.

Two professionals commented from visits they had made to the service that they were concerned about staffing levels one commented they did not believe there were enough staff to support people's needs.

Our observations informed us that there was not enough staff on duty to meet the needs of everyone in the service. We specifically observed people in the lounge over a 45 minute period, and then at shorter periods throughout the day. It was noticeable that one person who was not allocated one to one staff support throughout the day kept staff occupied constantly, levels of their repetitive behaviour increased and distraction techniques recorded in their behaviour plan, which required one to one intervention by staff were not implemented because staff did not have the time needed to carry out the distraction which could require them leaving the room with the person thereby leaving another person unsupervised. Other staff were attending activities outside the service and not available. As a consequence the person's behaviour escalated and impacted on another person in the room who had received even less staff time, but whose behaviour became more excitable. The registered manager was aware of pressures on staff time for one person in particular and was seeking a review of the hours they were funded for. There was no evidence of a staffing tool being used to aid this process. The lack of an appropriate staffing level directly impacted on how much time staff could spend with people. There were not enough staff to support everyone's needs this is a breach of Regulation 18 of the HSCA 2008(RA) Regulations 2014.

Medicines were administered by trained staff whose competency was routinely assessed. However medicines were not managed well. People could be placed at risk because ordering of some medicines had not been stopped and overstock was occurring. Some medicines no longer in use had not been returned to the pharmacy or crossed off of the medicine administration records (MAR). There was a lack of guidance to inform staff in what circumstances they should administer PRN or 'as required' medicines that are only taken as and when needed; this could impact on the consistency of administration by staff. All PRN medicines administered had to be approved by a registered manager first; an oral PRN medicine had been administered without being signed for, and without permission to administer being sought. Boxed, bottled medicines and topical creams were not dated upon opening (this is important for bottled medicines as opening can speed up the expiry date and affect the quality of the medicine). Some stock medicines had also been opened for no apparent reason. One person's medicine cabinet contained two bottles of the same medicine both open without dates of opening. A weekly medicines audit failed to highlight that medicines were not being dated upon opening, or disposed of appropriately. A monthly medicines audit had not been completed since December 2016.

People were at risk because the premises were not kept clean. The record of cleaning checks was unavailable to view the frequency of cleaning. There was an overall impression of grubbiness on doors, walls

floors and some surfaces. Faecal contamination of door handles, doors and surfaces from at least one person had not been addressed through a regular cleansing regime throughout the day to minimise risk of cross infection. An unused shower was in need of cleaning, showerhead descaling had not been completed and legionella testing had not been conducted since 2014 to ensure water quality remained safe. Wash basins in the laundry and medicines room needed cleaning.

There had been investment in the premises with some upgrading of bathrooms and bedrooms and people had been encouraged to be involved in some of the redecoration of communal areas. A maintenance team provided support for repairs and these were dealt with quickly in most cases, however some maintenance had been outstanding for some time. For example, a bath panel in an upstairs bathroom had jagged tiles at the bottom of the main panel; this could pose a risk of cutting someone's feet. The seal around the back of the bath taps was broken, rotted and lifted in places and this could lead to leaks, the bath taps were leaking even when turned off.

All equipment for fire prevention and electrical and gas installations had received an annual service. A fire risk assessment had been updated. People's needs in the event of a fire had been assessed in individual personal emergency evacuation plans (PEEPS) these were accessible to staff in grab bags should they need to evacuate the building. People could be placed at risk because the routine visual checks and testing of fire prevention equipment to ensure it was in working order was not always completed to the providers expected intervals. Staff received annual fire training and fire drills, not all however had participated in fire drills in the last 12 months. With none of the night staff recorded as attending who lone work and may not have an understanding of the actions to take in an evacuation. Only four out of ten day staff had practised fire procedures through drills. There was a risk in the event of a fire or emergency, the majority of staff would not be adequately familiar with the evacuation procedure. Health and safety daily walkthroughs were not conducted robustly to protect people from potential harm. For example, window restrictors were not included on this checklist, or hazards which may occur in bedrooms. Staff had not reacted to the garden shed doors being wide open and the risks posed by garden equipment.

Each person's plan of care was supported by a range of risk assessments; these were identified risks that each person may experience as a result of their individual care needs, health conditions or behaviours. The assessments included measures that staff should take or be aware of to mitigate the level of risks. Assessments of risk needed to be kept under review and amended in response to changing needs; however, some risks had not been reviewed or updated for a year or more, for example one person with a lack of capacity in regard to their personal hygiene or the impact of cross infection on others had not had this reviewed since 2014, the same person was at risk of absconding but measures in place had not been reviewed for over one year to ensure these remained adequate. The absence of a consistent routine of review posed a risk that some important changes in risk levels may be overlooked.

There were low levels of accident and incidents. These were analysed and informed changes to risk assessment and behaviour strategies if needed. Analysis showed two people were largely responsible for all incidents and there was good evidence that for one person current strategies were working and their incident levels reducing. However, for another person the impact of strategies was less evident, the person required a high level of staff attention and was not receiving this. Observations of staff working with the person showed that they were not always implementing the agreed de-escalation strategies.

People were at risk because there had been a failure to ensure that the systems in place to mitigate risks to the safe care and treatment of people had been implemented robustly and sustained consistently. This is a breach of regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

The provider ensured that all necessary recruitment checks required by legislation were carried out; however, the robustness of information supplied by applicants and checked by the organisation could not be evidenced from the staff files we viewed. One out of three files provided no evidence of a current photograph, declaration of health or personal identification, a second file was without evidence of a full employment history. The provider had failed to ensure that information specified in schedule 3 of the legislation was available in relation to each person employed; this is a breach of Regulation 19 of the HSCA 2008 (RA) Regulations 2014.

Staff confirmed that they had received safeguarding training and this was regularly updated. There was a safeguarding policy and this was kept updated by the organisation. Staff knew where it was kept. In discussion staff showed that they understood their role and reporting responsibilities to protect people from harm. Team meeting minutes highlighted that safeguarding featured on the agenda of staff meetings and staff confirmed that where they had lacked confidence around some aspects of safeguarding "There was something I didn't quite understand about safeguarding" this had been discussed with the registered manager as part of a learning session within the team meeting "I am much clearer about things now and know what to do". As a consequence staff felt more confident of raising concerns where they suspected or witnessed abuse; in the event that they were not satisfied that their concerns were being acted upon by the provider they were aware of other agencies they could raise their concerns with outside of the organisation.

Requires Improvement

# Is the service effective?

## Our findings

During the inspection staff on duty said they felt supported and felt that things had improved at the service since the new registered manager's arrival; they felt able to talk with the registered manager at any time.

A staff member said that the training they received was good. The said there were a lot of new staff who were having inductions and were shadowing more experienced staff on the rota. "I have found the registered manager to be very supportive, I have had regular supervision".

Systems were in place for the routine supervision and assessment of new and existing staff; these looked at development, training needs and overall appraisal of work performance. The provider had not consistently ensured that staff supervision was offered in line with their own guidance. Out of three staff records viewed none contained probationary reports including a newer staff member who commenced in April 2017; these meetings would provide assurance to the registered manager that the staff member was developing the skills and competencies they needed for their role. Another staff member had not received supervision since December 2016. Four staff qualified for an annual appraisal; this looked at their performance over the previous year and the setting of objectives for the coming year for their training and development; only one appraisal had been completed since the registered manager commenced at the service; others were overdue. Formal systems for the assessment and appraisal of staff performance and identifying their training and development needs were not being adhered to and is a breach of Regulation 18 of the HSCA 2008 (RA) Regulations 2014.

Staff had received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA 2005 provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff sought peoples consent in regard to everyday tasks. Two people were subject to DoLS authorisations but two others were not and yet everyday aspects of their care and support were also decided upon in their best interests by staff. In discussion with the registered manager there was not a clear understanding of when an application should be considered, with a view that this only applied to those people actively seeking to leave the premises. Due to the restrictions in place for people not subject to DoLS, accessing the kitchen, not being able to get access to food and drink when they wanted, having their medicines administered, having all aspects of their daily care and treatment decided upon in their best interests by staff, there was a clear need for a review of those not currently covered by a DoLS authorisation. There was a failure to ensure that the support staff provided to people and some of the restrictions in place had been considered under the Deprivation of Liberty Safeguards process as required, this is a breach of regulation 11 of the HSCA 2008 (RA) Regulations 2014.

New staff received a four day induction to the organisation and MAYBO training (this is a form of conflict management training for staff to help them work positively with people who may have behaviour that challenges others). Once located at the service new staff were initially supernumerary on shift and were required to complete their mandatory training through on line courses, familiarise themselves with policy

and procedure governing their practice and the operation of the service. They also spend time reading about people's needs and methods of communication, spending time with people and shadowing the experienced staff supporting them. All staff completed the Care Certificate (the Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life). Following completion they can be enrolled for a Diploma for Health and Social Care. Staff said they received a lot of training and did not feel there was anyone they supported who had needs they had not been trained to support.

A comprehensive programme of training was provided with access to specialist courses providing staff with a broader knowledge and understanding of the people they supported. The majority of staff training was in date. Where some were overdue, courses had been booked. There was a need to ensure that when new people were admitted that all staff received appropriate needs specific training. This should take place prior admission to ensure needs can be met and people are not placed at risk through staff ignorance. This had not always been the case for example, a night staff member who lone worked was without epilepsy training but supported someone with epilepsy. The person was not prone to seizures but there was a risk that should a seizure occur the untrained staff member would not be able to recognise it and ensure the person got the support they needed. This is an area we have identified for improvement.

Staff told us that the menu was devised weekly. Staff understood people's likes and dislikes and tried to involve as many people as possible each week in contributing ideas to menu development, using a range of picture prompts of meals and foods to determine people's preferences. A written menu was compiled for staff of main meals throughout the week. People chose their own breakfast and we observed one person under staff supervision making jam on toast for them self. People ate breakfast at different times but where possible staff tried to encourage people to eat their main evening meal together. The daily main meal was provided in picture format each day to a menu board in the kitchen so people could see what they were having for dinner that evening. The board was kept in the kitchen and was not always accessible to people, so consideration needed to be given to locating this elsewhere in communal spaces to keep people informed and this is an area we have identified for improvement.

People's health and wellbeing was being supported with evidence of appointments and contacts with health professionals and attendance at scheduled appointments. Health action plans were in place to detail people's individual health needs and how these were being supported. Hospital passports were in place to inform hospital medical professionals about how the person responded to health care checks and what they needed to do to support the person with their treatment and whether other people needed to be involved in health decisions. People's weights were taken on a regular basis and if weight loss was indicated they would be referred to their GP in the first instance.

Requires Improvement

# Is the service caring?

## Our findings

People were smiling and communicated happily using verbal communication, noises and gestures. Staff demonstrated they knew people well and used different communication approaches to suit individual people's preferences and level of communication.

Staff were discreet when carrying out personal care which was undertaken quietly, without fuss and doors were closed protecting people's privacy and dignity. In the majority of observations made people's dignity was upheld, however, we observed that away from personal care routines staff practices lacked understanding that maintaining a person's dignity was about more than, for example closing doors, or keeping their confidentiality. For example, staff knew some people needed to wash their hands more regularly than others, this was difficult to manage because of the frequency of hand cleansing this would require however did not see hand cleansing happening through use of hand wipes or hand washing, or surfaces wiped where other people might sit and eat, as a consequence other people and staff in the house were at risk from cross infection. This is an area for improvement.

At the beginning of inspection there was a relaxed atmosphere in the service with people seeking staff out to interact with rather than each other. We observed staff to be kind, warm and light-hearted in their engagements. One person was excited about celebrating their birthday that evening with other people in the house; they had chosen party food that they wanted to have that evening. Another person was happy to show us their room and reacted in a happy way to comments the registered manager made about their room. Although the person was nonverbal their exchange with the registered manager was light hearted and easy going.

The atmosphere changed a little towards the end of the inspection as one person became more and more restless which impacted on another person present. Staff however were calm when dealing with behaviours that were challenging and responded in an even manner using the correct responses to provide a consistent approach, but were not always able to introduce the distractions for some people which required dedicated time and patience. For example no observed intervention was implemented where staff spent time with the person encouraging and supporting them with a preferred activity such as going on the trampoline, going for a walk in the garden which were distraction techniques used to de-escalate behaviour. The person's unsettled state impacted on another person who was in the same area and became over excited.

People had their own bedrooms and they had been supported to personalise these with favourite posters, family photographs and small possessions that were important to them. Some people had keys to their rooms or were learning to use a key to prevent other people going into their room. Staff said that usually people respected each other's own spaces.

People were dressed in accordance with their preferences and when attending activities outside the service were seen to be supported appropriately to wear outdoor clothing suited to the weather.

Staff understood people's different methods of communication and were familiar with using pictorial

prompts and objects of reference forms of engagement with people. Staff spoke in an easy going and jokey manner with people and maintained a level response to those whose behaviour could be challenging over extended periods. Picture boards had been set up in some areas of the service for example, to show people who the staff were and who was supporting them each day.

People were encouraged to help with some aspects of housework, cooking, and laundry however small. One person had a 'jobs for the week' planner to help him manage his time in undertaking housekeeping requirements around his flat e.g. sweeping, emptying bins. The registered manager stated that this person was responsible for their flat but staff monitored this to ensure it did not become too untidy at which point they would offer more support and prompting. Goals and aspirations were set for people but the infrequency of key worker meetings and reports failed to show how or if the two people we tracked were achieving these.

People were supported to maintain links with their relatives and several people had regular arrangements in place for them to spend weekends staying with family.

Requires Improvement

# Is the service responsive?

## Our findings

During the day most people were calm and relaxed with some participating in activities outside of the service. Some people did not go out very often and one person became increasingly restless during the inspection.

A health professional told us that advice they had given previously to staff was not evident in staff practice when they had revisited and reviewed their input; they were not confident that staff listened to and acted on advice they had sought from professionals.

Our observations showed that some people were under stimulated and bored and the way one person was supported with their behaviour did not always reflect their plan of care. For example, their care record stated "I like to be on the go all the time, I have lots of energy and want to do stuff". During the inspection this person was not taken out until late in the afternoon but had increasingly showed signs of restless and repetitive behaviour that escalated steadily during the day eventually beginning to impact on another person's behaviour. The availability of staff and how they were deployed meant people could be delayed waiting for staff to return from outings with other people. Two people who spent more time within the service than others had activity planners more heavily weighted towards home based activities with occasional trips out including a weekly disco evening event. The frequency of trips out using the company vehicle was impacted on by the lack of available drivers; this affected those people who could be better supported in the company vehicle than public transport. At inspection there were only two drivers available across all shifts one of whom was the registered manager who mostly worked office hours Monday to Friday. People who needed to be driven places were limited to when and where they went

Some people had bus passes and were supported to use public transport. During the inspection three people enjoyed a varied range of activities outside of the service including attendance at the gym, and visits to the shops and walks. One person before they went out was able to tell us that they were going out on the bus to Folkestone independently, staff checked with them to make sure they knew where the person was going and when they would be back.

At inspection we saw no in house activities offered to those people who spent the majority of their time at home. Activity planners did not provide any prompts to staff as to the type of activities these people could be offered or a record made of what had worked well and not so well to inform updates to their activity planner. For example, one person spent time during the inspection in the communal area of the lounge and dining room, their record stated they liked music and particular DVD's, the television was on in the communal lounge but was not playing any music or DVD that the person might like. No one showed any interest in what was playing on the television and there was no music or visual stimulation provided.

Another person's record stated amongst other things that they enjoyed water play; in discussion staff said the only time this opportunity presented itself was when the person had a bath. We discussed other ways staff could offer this type of activity but a staff member commented "I would be embarrassed to suggest something in case I was thought to be offering something childish". A swing purchased for the person was

still to be erected. The garden provided an opportunity for sensory stimulation and activity but was unkempt, flower beds were overgrown and we were informed this was because people were expected to do the garden and staff were waiting for one person to start developing the flower borders. This seemed over optimistic and there was no realistic plan to move this along. We welcome the involvement of people in maintaining their garden but the expectation that they would develop the garden into a pleasant sensory area was unrealistic. Staff said that some people responded to sensory stimulation and the garden could be a good source of providing this. A staff member said (the person) liked to eat the fruit off the trees."

There was a lack of person centred activity plans and stimulation for some people and this was a breach of Regulation 9 Of the HSCA 2008 (RA) Regulations 2014.

Peoples care plans were individualised and written from the person's point of view. Care plans contained information about people's needs in respect of managing their health, social and personal care, and where possible people and their relatives were involved in their development and review. Each person had a key worker team that comprised a senior staff member and two care staff. There was an expectation by the registered manager that the senior staff member would take responsibility for compiling a monthly report about the person supported. This would detail what the person had done during the course of the month, including behaviours and incidents, progress towards achieving goals and aspirations and any changes in needs or risk levels. These reports informed the registered manager's update of the care plan. Monthly reports however were not routinely being completed, we found only one for June 2017 in one record and none in another. One person who required all personal hygiene support had not had their personal care routine reviewed and updated since 2014, they were at risk when out in the community but their support plan in regard to community based activities had not been reviewed and updated since 2014. A behaviour strategy for the same person had not been updated since 2015. People's mood and wellbeing were discussed in handover meetings to ensure staff coming on shift were apprised of any changes or recent developments but there was a failure to ensure peoples care records were kept updated to fully reflect their needs and any associated risks. This is a breach of Regulation 17 of the HSCA 2008 (RA) Regulations 2014.

People's needs were assessed prior to their moving in. We checked the pre-admission assessment and transition process of a person admitted to the service in recent months. The registered manager was involved in the assessment to ensure their needs could be met by the service. As part of the assessment process the person was visited in their last placement, they and their staff were spoken with and information was gathered from a number of sources to inform the decision to admit. A shorter transition to the service was arranged at a pace to enable the person to cope and deal with the change. Records showed that the person and their relatives were fully involved in the change of placement.

The majority of people were unable to tell us about what it was like for them living in the service. There was a complaints procedure and an easy read version; this was a mixture of easy read text and some pictorial prompts. The registered manager had identified a need to create another version more in tune with the communication needs of the majority of people in the service who used pictures and symbols, but this was not yet started. Staff understood people's behaviour and communication needs well and would recognise when people were distressed, sad or angry and would seek causes for this and take action where necessary. There was a complaints log but this was empty, the PIR had informed us that one formal complaint had been received and dealt with; this was not recorded in the log. The registered manager was able to discuss the complaint and the actions taken and provided a printed copy of the details of the complaint and the investigation. Whilst this showed that actions were taken to respond to the complaint it did not record whether the complainant was satisfied with the outcome and was not seeking to take this further. We discussed with the registered manager what further actions they could have taken to be assured the complaint was in fact closed and this is an area we have identified for improvement.

Requires Improvement

# Is the service well-led?

## Our findings

Staff said that there had been a change in the culture of the home; they thought that the present registered manager was doing a good job of establishing a team that felt more supportive of each other. Staff had no concerns about approaching the registered manager who they felt took time to explain things to them, gave them tasks to learn about policies and procedures and then asked questions of them at team meetings for example.

Staff told us, "We have a handover at the start and end of a shift so we can pass on information about what has happened, how people are feeling and other important information. We also record things in the communication book and on people's daily logs ".

There had been a high turnover of staff since the previous inspection in 2015 with the former registered manager and a number of the core staff team moving on. The current registered manager had therefore been involved in the recruitment of new staff and team building. Along with her line manager she had identified a range of improvements that needed to be made and a comprehensive action plan was in place for this. However progress in achieving improvements had been slow; where some improvements were seen to have been completed on the action plan these had not been sustained.

We checked with the registered manager what audits and checks the provider, registered manager and staff conducted on a daily, weekly, monthly, quarterly and annual basis. These audits were to provide assurance that the service was operating well and providing people with good quality support and care. On a daily basis staff undertook cleaning checks, kitchen checks, finance checks and health and safety walkthroughs. A weekly medicines audit by a senior staff member and a monthly broader medicines audit by the registered manager and a quarterly health and safety checklist were all used to provide an assurance that the service was running well. At inspection however, we found that audit processes were lax for example, cleaning was not being carried out to a good standard, attempts to check what was being cleaned and how often were prevented by the book used to record cleaning tasks being mislaid and a monthly infection control audit referred to in the locality manager's action plan was not available to view. Daily health and safety walkthroughs did not ensure that people's bedrooms were checked for new hazards given the wear and tear on furnishings and fabric and the condition of window restrictors was not checked at all. The weekly medicines audit was not carried out robustly and although was checked off as satisfactory had failed to note bottled medicines were not dated on opening. It did not record either that boxed oral medicines and creams were similarly undated once opened. Monthly audits to be conducted by the registered manager had not been completed since December 2016, and the registered manager did not have a good grasp of the poor medicine practices in the service.

A compliance review inspection by the provider's compliance team was conducted annually; the last being in August 2016 this had identified areas where improvement was needed. Shortfalls identified in the audits conducted at local and provider level informed an ongoing action plan for the service, but did not include identified actions from a finance audit. Progress towards achieving actions was monitored by the locality manager. The locality manager is a visible representation of the registered provider and responsible for

direct supervision of the registered manager, and for monitoring the progress of improvements. The PIR tells us that there had been 12 provider visits over the past 12 months mostly attributed to the locality manager. We viewed the action plan the locality manager monitored on their visits to the service, this was comprehensive and had highlighted some of the same areas we have identified at inspection. This was not however being monitored robustly to ensure areas highlighted as completed for example, cleaning schedules, infection control audits had in fact been implemented fully and sustained given the findings from inspection.

There was an absence of audits that checked documentation for content and accuracy, for example care plan audits were not conducted and so some care plans had support plans and risk information that was overdue for review and update. The registered manager was unaware that monthly key work reports, which provide people with an outlet to share their views and for staff to evaluate people's progress, were not consistently carried out. Tests and checks of equipment had not been monitored to ensure frequencies were maintained by staff, and shortfalls in staff attendance at fire drills had not informed actions to target those staff not participating. Supervisions and appraisals of staff had fallen significantly behind; the introduction of observational supervisions was not evidenced in staff records viewed. Recording in daily records of the activities people had participated in was poor. The system devised in the service for recording how core one to one hours were being used was not implemented consistently; this made it difficult for the registered manager to report on how one to one core hours were being utilised.

Surveys had been conducted but feedback from relatives had been minimal. Plans had been discussed to change how relative's feedback was captured; phone surveys had been suggested but not acted upon as yet. The registered manager thought this would work better as there was regular contact with relatives and relationships and communication with the majority of them was good.

Through the absence of some audits and the lack of robust completion of others the registered manager did not have a good oversight of what was working well and what was not working well in the service or where urgent improvements were needed. The failure to maintain a satisfactory system for the assessment and monitoring of service quality and ensure that operational records and those of people supported are accurate is a breach of Regulation 17 of the HSCA 2008 (RA) Regulations 2014.

Staff meetings were held on a regular basis although not necessarily monthly. Meetings were recorded and staff said they found these meetings useful. Staff said they thought staff meetings did provide an opportunity for them to discuss issues and seek clarification in some areas. Staff not attending the meetings could access the minutes to read what was discussed and any actions they needed to be aware of.

Staff had access to policies and procedures that were kept updated by head office. Staff were required to read and to sign they had read the highlighted new procedures and policy information, this will sometimes feature in team meeting discussions.

The registered manager understood her responsibilities to report all significant events to the Care Quality Commission and there was no indication that this was not been carried out satisfactorily. The registered manager had completed the PIR and sent this back to the Care Quality Commission in a timely manner.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating in the reception and on their website.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>There was a lack of person centred activity plans and stimulation for some people. Regulation 9 (1) (a) (b) (c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>There was a failure to ensure that the support staff provided to people and some of the restrictions in place had been considered under the Deprivation of Liberty Safeguards process as required. Regulation 11(3). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were at risk because there had been a failure to ensure that the systems in place to mitigate risks to the safe care and treatment of people had been implemented robustly and sustained consistently. Regulation 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There a failure to ensure peoples care records were kept updated to fully reflect their needs and any associated risks. Regulation 17 (1) (2) |

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There was a failure to maintain a satisfactory system for the assessment and monitoring of service quality and ensure that operational records were kept updated and maintained. Regulation 17 (1) (2) (a) (b) (c) (d) (i) (ii).

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to ensure that information specified in schedule 3 of the legislation was available in relation to each person employed; Regulation 19 (2) (3) (a). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not enough staff to support everyone's needs. Regulation 18 (1).<br><br>Formal systems for the assessment and appraisal of staff performance and identifying their training and development needs were not being adhered to. Regulation 18 (2) (a). |