Innova House Health Care Limited

Woodlands - Innova House CLD

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 13, 21 March and 11 May 2018. The inspection was unannounced. Woodlands - Innova House CLD is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Woodlands - Innova House CLD accommodates up to nine people and is designed to meet the needs of people with a learning disability. The premises comprise of five separate two bedroom houses situated around a shared communal outside area. On the day of our inspection seven people were using the service.

The care service has been developed and designed in line with the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. The aim is that people with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had a registered manager in place at the time of our inspection. 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.

Risks relating to people's care and support were not always assessed and planned for to ensure people received safe care and treatment. Staff helped people to take their medicines safely and at the right time however shortfalls were identified relating to people who self-administered and protocols regarding 'as needed' medicines. Staff were not given all the training they needed to support people with complex needs. The support staff received from their line managers, including formal supervision meetings to discuss and review their development and performance, was inconsistent.

Inconsistent pre-admission assessments meant staff were not always aware of people's background histories, preferences, routines and personal circumstances. Records, including risk assessments, in individual care plans had not always been updated and did not always accurately reflect people's care and support needs.

Inconsistent recruitment practices did not always ensure staff were suitably qualified, experienced or had the necessary skills to carry out their roles and responsibilities. There were not always enough staff deployed to support people's care and support needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People had access to health and social care professionals when necessary, however people's health conditions were not always known about by staff. Plans and guidance had been drawn up to help staff deal with unforeseen events and emergencies. Complaints were not consistently recorded and responded to in line with the service policy.

Although staff were kind and caring towards people who used the service, they had a lack of information available to them to ensure people would be supported in the way they preferred. There was sometimes a lack of involving people who used the service and their significant others in making decisions about their care and support. Care was provided in a way that promoted people's dignity and respected their privacy.

People were not always supported to pursue social interests and take part in meaningful activities relevant to their needs, both at the home and in the wider community.

Although people, relatives and staff were complimentary about the registered manager and how the service was run and operated, quality monitoring systems were inconsistent and audits did not always have the desired effect of identifying and addressing shortfalls in the service.

We found breaches of regulation in relation to the safe care and treatment of people, people's rights to make decisions, protecting people from the risk of harm and the governance of the service.

This is the second time the service has been rated Requires Improvement.

You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not consistently safe.

There was not always enough staff deployed, with the necessary skills and knowledge, to consistently and safely meet people's individual support needs.

Details, including personal risk assessments, in individual care plans did not always accurately reflect people's care and support needs.

Medicines were not always stored and administered safely.

Staff understood how safeguarding procedures helped to protect people.

People were not always protected by inconsistent recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff had training in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) the principles of the MCA were not always followed.

People were not consistently provided with a healthy, balanced and nutritious diet which met their needs.

Staff were not always confident and competent in their roles.

The service maintained close links to a number of visiting professionals and people were able to access external health care services.

People's wishes and consent were obtained by staff before care and support was provided.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff treated people with kindness, dignity and respect. However, people and, where appropriate, their relatives were not routinely involved in the planning and reviews of the care and support provided.

Staff respected people's privacy and promoted their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were at potential risk as Information, including staff guidance, in care plans, had not always been updated appropriately, to accurately reflect the individual's needs.

People were not always supported to develop their social interests and take part in meaningful activities, relevant to their needs and preferences.

People and their relatives knew how to make a complaint although they were not always confident any issues or concerns raised would be dealt with promptly and appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place were not effective in identifying risks and driving improvement. This placed people at risk of harm.

Audits were inconsistent and action plans did not effectively address identified shortfalls.

People and staff spoke positively about the registered manager and how the service operated.

Staff felt supported by the management team.

Woodlands - Innova House CLD

Detailed findings

Background to this inspection

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

We inspected the service on 13, 21 March and 11 May 2018. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience on the first day, three inspectors on the second day and two inspectors on the third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send 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. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with five people who used the service. One person who used the service had limited verbal communication so we also relied on observations and spoke with the relatives of three people to get their views. We also spoke with a health and social care professional who was involved in the placement of a person in the service six months ago.

We spoke with four members of support staff, the assistant manager, the registered manager and the person acting on behalf of the registered provider. We looked at the care records of six people who used the service, medicines records of three people, staff recruitment and training records, as well as a range of records

relating to the running of the service including audits carried out by the registered manager and registered provider.

Requires Improvement

Is the service safe?

Our findings

Robust systems were not in place to safeguard people from the risk of harm. Some people who used the service required support to manage serious risks to their health and wellbeing. However, guidance to ensure people's safety was not always followed and this placed people at risk of harm. One person's support plan stated the frequency of checks on the person must be increased in response to specific incidents. However, we reviewed a record of an incident and found checks had not been increased as specified. There was also guidance in the same person's care plan aimed at ensuring their safety in the community. Again we found evidence that this guidance had not been followed by staff. This failure to follow guidance placed people at risk of harm.

This person was at risk of harming themselves; however, we found their support plan did not contain sufficiently detailed information about the ways in which the person may harm themselves or what staff should do in each scenario to reduce the risk of harm. When we visited the service on the third day we found this person was no longer using the service but the registered manager told us they had learned from this and would ensure a more robust assessment and planning in the future.
There had been another person with complex needs admitted to the service between our visit in March and this visit. We looked at their care plan and saw there were robust risk assessments and care plans in place to ensure staff could support the person safely. Staff spoke knowledgably about this person's condition and were able to explain how they supported them. We checked to see whether the provisions referred to within the support plan and told to us by staff were in place and they were. This meant the risks to the person's health was reduced.

People who are diagnosed with autism can experience heightened anxiety and sensory overload and may have difficulty expressing how they feel and this can sometimes lead to people communicating through behaviour. We looked at the care records of two people who sometimes communicated through their behaviour and found there was a risk that opportunities for learning and the reduction of risk may be missed when these two people communicated through their behaviour. Incident records were not always competed as required. For example, daily records documented a recent incident where one of these people had placed themselves at risk. This had not been recorded on an incident form and consequently there was no evidence that action had been taken to learn from this to reduce future risk.

Where incidents records had been completed support plans had not consistently been updated to reflect learning. We reviewed incident records for this person which showed a pattern of triggers to anxiety and self-injurious behaviour. Despite this, the person's care plan did not include details of this specific trigger or provide staff with details of what they should do to minimise the risk of this. On the third day we visited this person was no longer using the service but the registered manager told us they had learned from the feedback we gave on the first and second day of our inspection and had implemented a system of 'root cause analysis investigation' to ensure that incidents such as this would be investigated fully with lessons learned and improvements made to minimise the risk of similar incidents.

Additionally a further person who used the service had a health condition which resulted in them having

seizures. There was a lack of risk assessment and planning in place to ensure staff had the information they needed to know what to do if the person had a seizure. We discussed this with the registered manager and on the second day we visited a plan had been put in place. However the plan did not detail what type of seizure the person experienced or how staff could recognise the person was having a seizure. When we visited on the third day the plan was still not fully robust as it did not detail the type of seizure the person had and how staff could identify the person was having a seizure. Following the third day of our inspection the registered manager sent us evidence that the plan had been updated with the required information.

Staff did not always have access to sufficient equipment to ensure people's safety. Some people who used the service were at risk of harming themselves by ligaturing (attempting to strangle themselves). Although we saw staff used specific equipment to enable them to remove a ligature this was not suitable for all ligature types. Additionally there were no checks in place to ensure the equipment was still working effectively. This meant there was a risk staff may not be able to safely remove a ligature and placed people at risk of harm.

Additionally a person who was monitored by staff at all times during the day was left for a short time whilst the staff member needed to fetch a food probe from another house due to the lack of availability in the house the person lived in. Although this was a short time the oven was on and the lack of equipment could have placed the person at risk of burning themselves.

Medicines were not always managed safely, although people we spoke with were satisfied they received their medicines in a safe and timely manner. One person told us, "A member of staff always does my medicine and they are all qualified, I take water with it and it's always on time." Another person said, "I self-medicate and I haven't had any issues. The medicine comes once a week. I've been working towards this for a few months; taking the medicine at the right times. I have it in my bedroom in a safe."

All staff responsible for administering medicines had received relevant training and their competency was regularly assessed. However, we saw where people self-administered their medicines there were not always sufficient measures in place to ensure their safety. One person was being supported to build their independence which meant they were able to manage some of their own medicines. A member of staff told us there were no checks in place to ensure the person had taken their medicines as required and the risk assessment did not address the risk of the person failing to take them. Furthermore, the risk assessment stated this arrangement would be reviewed if there were any concerns that the person may harm themselves using medicines. Despite this, we reviewed a recent incident record where the person had threatened to harm themselves using medicines, but no action had been taken to review their ability to safely manage their own medicines. We discussed this with the registered manager and they told us they would take action to address this risk. When we visited on the third day this person was no longer using the service and there were not any other people using the service who managed their own medicines.

Protocols in place to guide the use of 'as needed' medicines were not always adequately detailed. This meant staff did not always have clear information to guide the administration of these medicines. One person was prescribed 'as needed' medicine to help reduce their anxiety. There was a protocol in place but this did not detail any of the strategies to be tried before the administration of medicine and their support plan did not contain details of the 'as needed' medicine. This meant we were not assured 'as needed' medicines would be given appropriately.

When we visited on the third day of our inspection we found the process for the management of an 'as needed' medicine used to manage another person's behaviour and agitation was not effective. We noted the person had been administered this medicine on two occasions in the past three weeks. There were no

protocols in place to determine whether the threshold had been met to determine whether the decision to administer this medicine was the correct action to take. This could lead to inconsistent administration from staff. However, when we spoke with staff about this they told us administering this type of medicine was a "last resort". The records we viewed showed this medicine had not been administered frequently. The registered manager told us they would ensure the process for the administration of these types of medicines was made clearer in people's support records to avoid the risk of inappropriate administration.

This was a breach of Regulation 12 (2) a, b, g & h of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a risk of inappropriate or unsafe physical intervention being used. Some people required staff to physically intervene to ensure their safety in the event of a crisis, but guidance in care plans was not adequately detailed to ensure safe practices were followed. For example, one person's support plan stated that physical intervention may be used in 'extreme circumstances', despite this there was no detail of what sort of physical intervention could be used or how many staff would be required to ensure safe practices. When we visited on the third day of our inspection this person was no longer using the service.

In another person's care plan it was recorded that staff should stop the person leaving the service alone. The plan did not give staff information on how they should prevent the person from leaving. This person sometimes communicated through their behaviour and in order to protect another person in the service the care plan stated staff should obstruct and separate the two people. The plan did not inform staff how they should do this safely and in the least restrictive way. When we visited on the third day of our inspection we saw the registered manager had updated the care plan to include information about how staff should support the person in the least restrictive way.

We saw that staff had recorded on incident records that they had used a method called 'Assisted walking' to move the person away from harming themselves or others. However this method of restraint was not recorded as a technique which had been agreed for this person. Additionally the care plan in place to inform staff how to anticipate and respond to this person's behaviour was inappropriate. The plan stated that if the person's behaviour had escalated to the highest level staff should remind the person to wash their hands after using the toilet and ask them to clean up any mess they had made. This information would not be helpful to staff to support the person appropriately in a crisis situation.

This was a breach of Regulation 13 (4) b of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with said they felt safe living at Woodlands; one person told us, "I feel safe because you've got a member of staff here." Another person said, "Yes I feel safe, some of the staff are alright, some I don't like." However, when asked if they felt safe, one person told us, "I do and I don't. " They went on to describe feeling intimidated at times by the person they shared a house with. They told us, "I feel safe when [Name] isn't here." We discussed this issue with the registered manager, who confirmed they were aware of the situation and, following relevant consultation, were in the process of transferring one of the people to a more appropriate placement, within the service.

Relatives told us they were satisfied their family member was safe. One relative told us, "Yes I feel reassured [family member] is safe here and they never go out on their own. The staff go places with him and he's a lot more settled in his ways. He seems a lot happier in himself and I think he feels safe here." Another relative said, "I think the staff here do as much as they can within the parameters of the law. There have certainly been no instances I can think of when [family member] has been unsafe here."

Staff were deployed in sufficient numbers to meet people's needs and help ensure their safety. However we saw in duty rotas that on occasions agency staff were used, which had an impact on the consistency of care and support. For example, one member of staff described how the person they supported would become anxious and upset with people they didn't know. They told us, "We do sometimes have to use agency staff. It's not ideal because they often don't know the service user or their routines." We discussed this issue with the registered manager, who confirmed they occasionally used agency staff to cover sickness or annual leave, but insisted this was always a last resort and only if permanent staff were unable to provide cover. Records showed when a person required continuous supervision (sometimes referred to as one to one or two to one support) the appropriate number of staff were in place to support them. When we visited each person, we spoke with these staff and they told us there were always enough staff to support people. This ensured people received the care and support they needed to keep them safe. Records showed the required number of staff were available to provide people with their one or two to one support.

People and their relatives said they felt the service was generally kept clean and well maintained. One relative told us, "It has always been clean every time I've been there. I don't like messy bedrooms. [Family member] doesn't like to tidy their bedroom; we still have to prompt them." We saw there were cleaning schedules in place in each house to ensure routine cleaning was undertaken to promote cleanliness and hygiene. Staff we spoke with had an understanding of what products and equipment should be used for different cleaning tasks and we saw these were available along with protective gloves in the houses. However staff did not have protective aprons available in the house to use when supporting people with personal care. This meant there was a risk of the spread of infection when staff had supported people with personal care and then went on to prepare food in the kitchen area.

People were living in a well maintained environment and there were systems in place to minimise risks of injury from the environment. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and control measures were in place to reduce these risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency. A risk assessment had been carried out to assess each house for the risks related to legionella and there were steps being taken to reduce these risks. Some recommendations made through the risk assessing process had not yet been acted on but the registered manager assured us these would be added to the action plan for improvement of the service.

Requires Improvement

Is the service effective?

Our findings

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

People's support plans contained assessments and best interest decision forms designed to show how people's capacity to make certain decisions had been assessed and if the person did not have the capacity what decision had been taken in their best interest. However, where it had been determined a person did not have capacity to make a decision it was unclear from the documentation what decision had been agreed. Additionally one person sometimes needed staff to physically intervene to keep them or others safe when the person communicated through their behaviour. A plan had been put in place to inform staff what physical intervention could be used, however the person's capacity to understand this had not been assessed or planned for. This meant the principles of the MCA were not always followed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had made applications for DoLS where appropriate. For example, two of the care plans we looked at showed both people had been assessed as requiring support from staff if they went out into the community and they were not free to leave the service alone. There was an up to date DoLS authorisation in place for both people. However the conditions attached to the DoLS authorisation were not always adhered to. One person had a number of conditions and from speaking with staff and looking at records we saw two of these conditions were not being adhered to. For example one condition was for staff to record the person's psychological state prior to any incidents of them communicating through their behaviour and records showed staff were not doing this.

This was a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with had mixed views regarding whether they felt staff knew them well and were aware of their individual needs and the best ways to help and support them. One person told us, 'Yes definitely they do. I think the staff here are good all round, every single one of them. They know us and know what we need and I like all of them." Another person said, "No the staff don't all know how to deal with my sort of issues; maybe a couple do but I don't know if they have training."

The needs of some people who used the service were very complex and varied from house to house and

staff worked in all of the houses. Staff were not given training on all of the needs of individuals, such as one person was at high risk of self-harm and staff did not have the training needed to know how to respond to this appropriately. When we visited on the third day of our inspection the registered manager told us of the work they were doing to assign specific staff to each of the houses to ensure staff could be given the skills and training to support people's needs and to gain the experience of supporting specific complex needs.

There was a risk people's care and support may not be coordinated when they moved between different services. During the course of our inspection the provider developed 'hospital passports' to try and ensure key information was shared with hospitals if people required treatment. However, we found these did not always contain sufficient detail to ensure hospital staff had the information they needed to provide an effective and person centred service. For example, one person sometimes behaved in a way that placed them at risk of harm, this important information was not reflected in the hospital passport. In another person's care file the person's 'hospital traffic light' assessment was blank. The failure to ensure these documents were completed and up to date could result in people not receiving the appropriate care and support they needed. The registered manager acknowledged this should have been completed and told us they would do so immediately.

People's health conditions were not fully assessed or planned for. There were risk assessments were in place in relation to some aspects of people's identified care and support needs and behaviours, for example one person had a diagnosis of epilepsy. However this was not detailed in a section entitled; 'Things you must know about me'. There was also no related guidance for staff in relation to how to recognise and deal with associated symptoms. We saw their support plan contained interventions and strategies to manage potential risk, when in the community, related to road safety, traffic awareness, including the use of physical restraint. However there was no evidence these assessments had been reviewed or updated, which meant they did not accurately reflect the individual's changing needs and consequently placed them at potential risk of harm.

People were not fully supported with their nutritional needs. One person told us, "I don't eat properly. I basically just eat crisps, no one checks up. My favourite drink is Pepsi Max. I have the occasional cup of tea about once a month." Another person said, "I like junk food. The staff cook for us though but I can put a microwave and kettle on." The behaviour plan of one person showed they sometimes purged on food to communicate their needs. However this was not mentioned in their eating and drinking care plan and there was no information for staff on how to monitor this. There was a lack of menu planning in the houses to ensure people were eating a well-balanced healthy diet.

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

We looked at the staff training records and saw that staff were completing training which the provider deemed as mandatory such as first aid, safe administration of medicines and infection control. One member of staff told us they felt they had enough training to carry out their role and said, "There is a lot of training here." Another member of staff said, "This is the best place I've worked for training and we always seem to be having training in something or other." They went on to say, "I told my manager I needed training in completing ABC charts and they arranged it." This was supported by staff training records we looked at.

Relatives spoke positively about the staff and generally felt they had the necessary knowledge and skills to meet the care and support needs of their family member. One relative told us, "Yes, all the staff I've dealt with are fantastic. I've had no worries about how they're treating [family member]. I'm very happy." Another relative said, "'I think so, they seem to know what they're doing."

People who had the capacity to do so were supported to make decisions on a day to day basis. We observed that people decided how and where they spent their time and made decisions about their care and support. We asked people whether they were involved and supported to make important decisions about their lives. One person told us, "Yes, over the last few months I have had monthly meetings with the social worker and manager. I negotiated self-medication and reduced hours. I've been involved and listened to and feel this has had a big impact on my life." Another person said, "Last year I got in contact with my [close relative]. I was nervous but the staff were always there reassuring me, saying it's completely up to me, as long as I'm safe and legal." They went on to say, "They've been like that since day one and have been very supportive about my relationship and new flat."

The registered manager had taken steps to ensure people had access to information that enabled them to understand their care needs and the health services available to them to ensure people were not unduly discriminated against. A range of information was available in 'easy-read' format. On the first day we visited this information was not available in the individual houses, however the registered manager had implemented a folder with information on safeguarding, making complaints, equal rights and other important information in each house to ensure people had access to this information.

People lived in a service which met their needs in relation to the premises. The service had been designed to create small homes for up to two people to share. Each house was designed to support people to live an independent life as possible and each opened up into an accessible shared garden.

People were supported with their day to day healthcare. We saw people were supported to attend regular appointments to get their health checked. Staff sought advice from external professionals when people's health and support needs changed. For example staff had involved a Speech and Language Team (SALT) to support one person with communicating their needs.

Requires Improvement

Is the service caring?

Our findings

People were not routinely involved in the development of their support plans. We reviewed a newly developed support plan and found no evidence to demonstrate the person had been involved. We spoke with a member of staff about this who told us the plan had been written by staff and the person had then been offered the opportunity to read through it, which they declined. This failure to involve the person in the initial development of their support plan meant opportunities had been missed to enable people to contribute to the planning of their own care. This person had the skills and ability to fully participate in the development of their care plan but this opportunity had not been offered to them.

Staff did not have access to information about people's life history or what they had achieved. The care plans did not contain information such as this and neither did the short plans available to staff who were supporting people. Two staff we spoke with said they did not know about people's lives prior to them moving into the service. This posed a risk that staff would not have the information they needed to ensure people's needs were met in an individualised way.

People and their relatives spoke positively about the caring environment at Woodlands and the kind and compassionate nature of the staff. One person told us, "Staff here are lovely, very kind and caring, I can't fault them." Another person said, "Kind? Oh yes!' They laughed and went on to say, "This is the first place where the staff are my friends and I can talk to them." We asked one relative about the kindness of staff and the level of care provided. They told us, "100%, I can't praise them enough. They contact you even if [family member] has a cold."

This view was shared by other relatives we spoke with; one told us, "[Family member has made a lot of progress." Another relative said, "The staff are fantastic, I can't fault them, they are so kind and encouraging. [Family member] is doing so much more now than before; cutting food up and learning how to look after himself. He has a diary so I try to put something supportive in." Throughout the day we observed caring friendly and good natured interactions between staff and the people they supported. This demonstrated people were treated with kindness and compassion in their day-to-day care and support.

People's religious beliefs were planned for. Care plans included people's religious beliefs and how these would be met. One person had a religious belief and we saw this was detailed in their care plan and staff told us the person's family supported them to attend their chosen place of worship each week.

We spoke to the management team about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. There were three people currently being supported by an advocate, which showed people were supported to access an advocate. We discussed with the registered manager the lack of information available for people to understand their rights to use an advocate and the registered manager assured us this information would be made available.

People were supported to be independent. For example, we observed two people in one house who had control of most aspects of their life, such as doing their own laundry, planning and preparing their meals

and deciding what they would do each day. Staff told us that other people were supported to get involved in daily living skills such as doing their own laundry and we observed this to be the case during our inspection.

Requires Improvement

Is the service responsive?

Our findings

There was a risk that people may receive inconsistent and potentially unsafe support as they were supported by staff who did not have information about important aspects of people's life and risks posed during day to day activity. We found on the first and second day of our inspection that there was a lack of assessment records to show that people's needs had been assessed prior to them moving into the service to show their needs could be met with the staffing and facilities at the service. The lack of assessment also meant there was a lack of information about people's lives and preferences. Care plans detailed people's religious preferences but lacked other information in relation to the six strands of equality such as people's sexual orientation.

When we visited the service on the third day of our inspection there had been a new admission to the service. We saw that prior to them moving into the service, assessments had been carried out to ensure that when the person moved into the service, their needs could be met. Once it was agreed they could be supported safely more detailed support plans were put in place. We saw the most serious risks to their safety had been appropriately assessed and immediate support was in place. This ensured the person had a smooth transition to the home.

Staff told us they were not permitted to read people's care plans until they had worked in the service for six months. They told us this was due to a potential breach in people's confidentiality if the staff member decided to leave the service after a short time. Staff told us they had access to a shorter care plan to enable them to understand people's needs. We looked at the shorter care plans and we saw they did not contain enough information to give staff a full picture of people's preferences and needs. We discussed this policy with the registered manager and they agreed this practice should be reviewed and that staff should have the opportunity to read people's care plans to ensure they had information about people's preferences and needs.

Some support plans did not contain adequate information and did not reflect people's needs. During the course of our inspection we identified one person's support plan did not accurately reflect their needs and gave conflicting information to staff. The provider took swift action to develop a new support plan. However, we found the quick reference information that was used by new and agency staff had not been updated and consequently did not reflect the person's needs. Additionally the newly implemented support plan still did not contain enough information to ensure the person was protected from the risk of harm and there was still inaccurate information in the plan. For example the plan stated that staff should use a certain technique to support the person in relation to their behaviour. The service had not used this technique for some time and staff were no longer trained in how to use it. This placed the person at continued risk of inconsistent and potentially unsafe support. When we returned to the service for the third day of our inspection the registered manager told us they had now changed the policy on staff reading people's main care plan and that all new staff would be supported to read these. She also told us that all care plans were being updated to ensure they reflected the current needs of people.
We noted the continence support plan for another person was not up to date and did not currently reflect their current health needs in this area. This person's records showed that staff were not currently providing

adequate support for the person to ensure their continence was managed appropriately and this placed the health and dignity at risk. We found numerous examples written in the person's records where they had been found to have soiled their clothing. The registered manager told us that a health care professional was due to meet with this person and to offer guidance for staff on the most appropriate way to support them. This, the registered manager told us, would reduce the frequency with which the person was found in soiled clothing and reduce the risk to the person's dignity. The registered manager implemented and sent us an updated continence plan following our visit.

Care plans lacked information on people's preferences for when they reached the end of their life. This meant there was a risk that people's preferences would not be respected if they died unexpectedly.

People were not always given the opportunity to socialise and take part in activities they liked. We observed one person who spent most of their day sitting in the lounge on both of the days we visited. This person's care plan stated they needed to have two staff to support them into the community and the registered manager told us the person had recently been funded for this for 14 hours per week. However when we asked staff how often the person went out into the community they told us this was dependent on what staff were available and described the person being supported to go out a number of weeks prior to our inspection. We looked at the person's records and there was no evidence that they had been out into the community for 14 hours in the week prior to our inspection. The assistant manager agreed that having an activity record would provide a clearer oversight to monitor the person was receiving support to go into the community as detailed in their care plan.

There was a lack of structure for people to choose and take part in activities. We saw two people had an activities plan in place for the week, however we discussed this with two members of staff and both said the plans would not happen in practice. When we returned to the service on the third day of our visit we saw that 'activity choice boards' had been implemented for all of the people using the service. These were in picture format and gave people a choice of activities each day. We checked one person's activity choices for the day we visited and saw the activities were given in line with the choices made.

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

People were not fully supported to raise concerns. On the first day we visited there was a lack of information in the houses informing people of how they could raise concerns and what would happen if they raised concerns. Additionally a relative told us of a concern their relation had raised about a member of staff. They did not feel this had been dealt with and were concerned about this. We looked at the complaints log and this concern had not been recorded and the registered manager was not aware of the concern as they had not been in the service at the time. We asked the registered manager to investigate this and when we returned to the service for the second day of the inspection we saw this had been done by one of the management team. The person had described what their concerns were and how staff could have avoided the issue but said they did not want any action taken as it was in the past. The investigation therefore ended at that point and there was a missed opportunity to learn from what had happened and minimise the risk of this happening again in the future.

The service had looked at ways to make sure people had access to the information they needed in a way they could understand it to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Individual support plans we looked at included sections on effective communication. For example, one plan

incorporated the aim of supporting the person to communicate, to develop ways of them expressing their thoughts, feelings and preferences and to provide positive communication aids. This was linked to specific staff guidance including the use of verbal and non-verbal prompts and a section, 'About me' which described the person's ability to communicate by facial expressions, body language and pointing and tapping. During the inspection we observed staff sensitively used these methods to effectively communicate with the person. This demonstrated the provider had considered and addressed the communication needs of people with a disability or sensory impairment.

Requires Improvement

Is the service well-led?

Our findings

There had been a period of instability in the management team and this had resulted in deterioration in some areas of the service. There was a registered manager in post who had been on maternity leave for almost a year and had recently returned to work. During this time there had been changes to the management team and the nominated individual (acting on behalf of the provider) had needed to spend less time in the service. This had led to a lack of robust oversight and governance in the service and impacted on people being placed at risk of harm.

The systems in place to monitor the quality of the service were not always effective. There were audits in place to check staff were following safe food hygiene policies in relation to the kitchens in the houses. However on the day we visited we found a number of issues with the way food was stored. We found people were being placed at risk of having food poisoning because basic food hygiene practices were not being followed. In all three houses we found a number of items in the fridge which had no date of opening on them so that staff would know if they were still safe to give to people. Some of these items needed to be consumed or destroyed within a set period of time but due to staff not date stamping the items when they were opened there was no way to tell how long they had been open. We also found an open packet of cheese stored next to raw meat. We discussed this with the registered manager and they took immediate action, destroyed the items and put in place checks to ensure staff adhered to safe food hygiene practice. However when we returned to the service for the second day we found this was still an issue. When we returned to the service on the third day of our inspection we found action had been taken to improve this and the food in the fridges was clearly labelled with a use by date and these were being adhered to. The registered manager explained they had changed the auditing process and this was being monitored.

There were audits carried out in relation to other areas of the service such as the safety of the environment and we saw these were identifying some issues and action was taken to remedy these. However we saw these were not always effective in identifying issues. We saw there was a leak under the sink in one house and this had resulted in the fire extinguisher test date being obscured. This had not been picked up by the audit prior to the first day we visited, nor the audit which had taken place following the first day we visited.

Opportunities for learning from events were missed due to a lack of oversight of incidents. We saw that there were systems in place to monitor incidents in the service which included checks by the management team to assess if there was any learning from incidents and if staff could have responded to the incident in a different way. However we looked at a number of incident records and saw these were not always being checked by the management team and the part of the form for management completion was either blank or had been filled in by support staff. The systems were not being operated effectively. When we returned to the service on the third day we found this was still an issue and the incident forms were not being signed off by the registered manager and this posed a risk that inappropriate management of the incidents might be missed. Where there was a major incident in the service the registered manager was carrying out a thorough investigation of the incident and identifying where improvements could be made to prevent similar major incidents from happening.

In addition to this there was disorganisation of where the care plans were stored. When we asked to see care plans staff were sometimes unsure of where they were and rather than being stored in the house where individuals lived they were sometimes found in the office or in another house. This posed a risk that if staff needed to access a person's care plan in an emergency situation they may not be able to find the information needed to support that person. It also showed that care plans were not routinely read by staff to ensure they knew about changes to people's support needs. When we visited the service on the third day of our inspection we found the care plans were being stored appropriately in the house where the individuals the care plans were written for lived.

Staff recorded on a daily record in relation to all aspects of people's care and support. We found seizures were not being safely monitored and managed. If people with epilepsy had a seizure these were recorded in the daily record rather than in a separate record. This would make it difficult to monitor and analyse seizures for trends to assess if there could be any learning from the events surrounding the seizure. Activities completed were also recorded on the same chart and this made it difficult to analyse if people were carrying out planned activities such as specifically funded visits into the community. For example one person had recently been funded for 14 hours per week for two staff to support them to go out of the service and do activities they enjoyed. There was no system in place to monitor if this was actually happening. One of the management team immediately put a chart in place when we pointed this out to them but this had not been considered for all people who used the service prior to our visit. When we visited the service on the third day of our inspection we saw an epilepsy log and daily activity records had been implemented to ensure future analysis and monitoring was more streamlined.

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

The service promoted and supported fairness, transparency and an open culture and the registered manager and newly appointed nominated individual informed us at the start of the inspection that they knew there were issues in the service. They had put in place an action plan and this showed they had already identified some of the issues we found. They told us they were working hard to make improvements and drive the service forward and that they had the full support of the provider.

The structure to ensure staff of different designations knew their roles and responsibilities and carried them out was not robustly embedded in the service. The registered manager described how this was going to improve to ensure staff had defined roles and oversight in different areas of the service, based upon their skills. This involved a restructure with 'champions' of different roles such as dignity, training and positive behaviour support to develop a more holistic approach in the service.

The registered manager told us the registered provider was a regular visitor and was supportive of any changes or improvement needed. Following our inspection the registered provider contacted us to give assurance that improvements needed would be made.

The management team had processes in place that ensured the CQC and other agencies, such as the local authority safeguarding team were notified of any issues that could affect the running of the service or people who used the service. The provider was not displaying the rating they were awarded at their last inspection according to guidance given by CQC. The registered manager explained that the website had been locked down by the developer and they were working to get this resolved. In the meantime there was a link to the latest report available from CQC.

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 The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9 (1)(2)(3)(a)(b)(f)(I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principals of the Mental Capacity Act 2005 (MCA) were not being adhered to. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. Regulation 12(1)(2)(a)(b)(c)(e)(f)(g)(I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not be protected from abuse and improper treatment. Regulation 13(4)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were not effective and this placed service users at risk of harm. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:

We served a warning notice telling the provider they must become complaint with this regulation by a date set by the Commission.