CareTech Community Services Limited

CareTech Community Services Limited - 237 Kenton Road

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

Overall summary

This inspection took place on the 25 and 26 June 2015 and was unannounced. At the last inspection on the 17 July 2014 we found the provider was not meeting two regulations in relation to supporting staff and care and welfare in meeting people's individual needs through the provision of meaningful activities.

Following the inspection the provider sent us an action plan telling us how they were going to address the concerns and that the appropriate measures would be in place by 5 June 2015. During this inspection we found that the provider had taken some action but it was not sufficient as there were still concerns in relation to staff

Summary of findings

not being supported to enable them to care for people effectively and people not receiving person centred care and being engaged with meaningful activities. Further breaches of regulations were also found in relation to staffing levels and quality assurance systems not being robust enough to effectively assess, monitor and improve the quality and safety of the services being provided to people.

CareTech Community Services Limited - 237 Kenton Road is a care home that provides personal care and accommodation for up to twelve people who have learning disabilities.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous registered manager had left the service. A new manager had been appointed who had been in post for three months. The new manager had not yet registered with the CQC.

Relatives spoke positively about the service. They told us "We are very pleased with the way [person] is being cared for, I am very pleased [person] being at this home", "They are kind and [person] is happy".

There were insufficient staffing levels to deliver care that met people's individual needs and ensure their welfare and safety. People's safety was being compromised as they have complex needs and required one to support with their care. They were being left unsupervised during the day as care workers were busy with other people in the home or involved with household chores.

People using the service experienced a lack of consistency in the care being provided. Care workers told us there had been many staff changes and absences that had affected the service and their duties were shared out between agency, bank and permanent staff. Care workers felt this placed extra pressure on them to ensure people received the support they needed.

Some risks to people were identified and managed so that people were safe and their freedom supported and protected. However there was limited information about the safe practice of moving and handling and there were no specific risk assessments for people who were visually impaired.

Although staff had received some additional training they did not feel they were supported to have the necessary knowledge and skills they needed to support people with complex needs and people with a visual impairment. Staff told us they felt demotivated and felt there was a lack of direction at the home.

There were some arrangements in place to obtain, and act in accordance with the consent of people using the service. Care plans contained some information about people's mental state, levels of comprehension and the support needed for a person. However, there was no information about the attempts that had been made to support some people who lacked capacity and had limited or no contact with their families, to involve them in the planning of their care and seek independent advocates if necessary.

People were supported to maintain good health and have access to healthcare services and received on going healthcare support. Each person had a Health Action Plan and which outlined people's medical backgrounds, allergies, current medicines and records of appointments with healthcare professionals such as GPs, dentists, psychiatrists and opticians.

There were comprehensive communication profiles which detailed how people using the service were able to communicate. We observed care workers communicated with people in a way that was understood by them.

All the people using the service were attending day centres and people were taken out into the community. People were supported to maintain relationships with their family members.

We saw people were treated with respect and dignity and kept safe. However people did not receive person centred care. We observed people using the service sitting for periods with no planned activity and little to do. Care workers were not engaging or involving people in a meaningful manner and did not spend any quality time with people. Care workers were more task focused which

Summary of findings

means care workers were more focused on household chores and tasks relating to their work rather than spending quality time with people, engaging and involving them in meaningful conversation or activities.

The current systems in place were not robust enough to monitor and improve the quality of the service being provided to people using the service. Effective measures had not been put in place which showed the provider had addressed the concerns raised at the last inspection and had made improvements to the quality of care being provided to people.

Relatives spoke positively about the new manager and told us "[Person] is happy with him. He is much kinder. I am very impressed, he is professional. Things seem to under control" and "I have spoken with the new manager and he is a nice person."

The new manager told us he was looking into areas where the service could be improved and was producing an action plan which he wanted to implement to ensure the quality of service improved and any concerns raised were addressed.

We made four recommendations about reviewing risk assessments, arrangements in which people's finances are managed, MCA and DoLS practices and arrangements for how people can express their views.

We found four breaches of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

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

Aspects of the service were not safe. There was a lack of consistency in the level of care being received by people. There was insufficient competent staff deployed to meet people's needs. People with complex needs were left unsupervised as staff were busy tending to household chores.

Some risks to people were identified and managed so that people were safe and their freedom supported and protected. However information was limited and did not address all the areas where a person could be at risk of harm.

There were safeguarding and whistleblowing policies and procedures in place. Staff undertook training in how to safeguard adults and were aware of what action to take if they suspected abuse.

Is the service effective?

Requires improvement

Aspects of the service were not effective. Although staff had received some additional training, staff were not receiving the necessary support needed to provide care and support for people with complex needs and people with a visual impairment.

There were some arrangements in place to obtain, and act in accordance with the consent of people using the service however there were no independent advocates for some people who lacked capacity and did not have any family support.

People who lacked capacity were not supported to be involved and make decisions about their care and support.

Is the service caring?

Requires improvement

Aspects of the service were not caring. People received basic care and the support they received was task focused.

There was limited support and encouragement for people to do things independently and to develop their daily living skills.

People were being treated with respect and dignity.

Is the service responsive?

Requires improvement

Aspects of the service were not responsive. People using the service were not receiving person centred care and were not engaged in meaningful activities.

We found some action had been taken by the provider, all the people using the service now went to a day centre during the week. A day centre had also found been that catered for the needs of people with a visual impairment which they attended.

Summary of findings

Some people using the service had been allocated a fixed number of hours for one to one support to enable them to go out in the community and engage in activities. However it was not evident whether this was being done effectively due to insufficient numbers of staff in the home.

Is the service well-led?

Aspects of the service were not well led. The previous registered manager had left and staff felt there was a lack of direction. However care workers spoke positively about the new manager now in post.

A recent audit had been conducted by the provider and we found some deficiencies in the service had not been identified and where there were areas that needed improvement this had not been addressed or actioned.

We saw there were systems in place for the maintenance of the building and equipment to monitor the safety of the service.

Requires improvement

CareTech Community Services Limited - 237 Kenton Road

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 provide a rating for the service under the Care Act 2014.

This inspection was carried out by one inspector and was supported by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before we visited the home we checked the information that we held about the service and the service provider including notifications and incidents affecting the safety and well-being of people. No concerns had been raised.

There were ten people using the service. All the people had learning disabilities and could not always communicate with us and tell us what they thought about the service. Because of this, we spent time at the home observing the experience of the people and their care, how the staff interacted with people and how they supported people during the day and meal times.

We spoke with five relatives and one advocate. We also spoke with the new manager and four care workers. We also reviewed four people's care plans, three staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Requires improvement

Is the service safe?

Our findings

All the relatives we spoke with told us they felt people were safe in the home. An independent advocate for one person using the service told us "There is nothing I am worried about at the moment. [Person] is very happy there"

We found staffing levels were insufficient to deliver care that met people's individual needs and ensure their welfare and safety. The people using the service had complex needs and were unable to verbally communicate their wishes. Two people using the service also had a visual impairment and needed support from staff with their mobility. The service has two units. Each unit had two care workers looking after five people.

During the inspection, we observed staff accompanied people to go out for lunch and some people went to a day centre. However there were occasions throughout the day where there was only one member of staff supporting people using the service as other care workers were busy with other people in the home or involved with household chores. There were instances we observed people using the service were left on their own whilst the care worker made lunch and dinner. This we observed happened in the afternoon and early evening and people were left on their own for ten to fifteen minutes. In one instance, during the early evening, one person who was visually impaired and required support with their mobility was left in the living room with another person using the service for ten minutes whilst the care workers cleaned the kitchen after people had eaten their dinner.

Such instances could compromise the safety of people using the service as they have complex needs and require one to support with their care. People were being left unsupervised at numerous times during the day due to insufficient numbers of staff in place to ensure people's needs in all areas were being met effectively.

We observed there was pressure on care workers to support people. Although there was a rota in place and two care workers were allocated to work in each of the units, we observed this was not put into practice due to the insufficient numbers of staff. Care workers would be floating between the units to ensure any support needed by people and household chores was covered. Feedback from care workers reflected our concerns who felt the home was understaffed. Care workers told us "We are short staffed. I withdrew from the training this morning as I had to look after [person], "They need to have more staff, we are not achieving the one to one for people as we have to help with other things in the home because there is not enough staff", "There is not enough staff, we are always understaffed" and "There is one care worker to do all the work, no one can sit with the residents and we need more one to one time with the people for activities and take them out to the community. People are happy to be taken out and we need to be able to do that."

People using the service experienced a lack of consistency in the care being provided. One relative told us "It is mixed when it comes to the staff. Some can be more laid back than others." During both days of this inspection we observed bank and agency staff were being used alongside the permanent staff. We observed the bank and agency staff had very little interaction with people using the service. Care workers told us there had been many staff changes and absences that had affected the service and their duties were shared out between agency, bank and permanent staff. Care workers felt this placed extra pressure on them to ensure people received their support. Care workers told us "With the new staff, we always have to explain to them what to do and that takes our time off the other residents and you cannot be always sure they understand the person's needs well enough", "It would be good to have a consistent team. There are too many different people. We need more permanent care workers" and "We have had staff changes, manager changes, the people here see different faces and there is not enough familiarity for them. It is not good for them."

We spoke with the new manager and he told us the provider has a system in place where if he required additional staff he would contact the head office who would then allocate a bank or agency care worker to the home. He told us they used bank and agency staff that had worked at the home and with the people using the service. However we noted there was no consistency in the way bank and agency care workers would be allocated as it was done as and when it was needed and dependent on which care worker was available.

The above was evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some risks to people were identified and managed so that people were safe and their freedom supported and

Is the service safe?

protected. People's care plans contained two sets of risk assessments, one set were generic assessments which covered the same areas for each person such as using the company vehicle, participation in activities, using the kitchen and protection from the sun. People's care plans also contained a "How I keep safe in this area" document which were more specific to people's individual risks. For example, one person using the service had a fear of dogs when in the community and measures were outlined for staff to ensure the person avoided this risk and was kept safe.

However, we noted that there were no specific risk assessments in place for two people who were visually impaired which clearly identified the risks they could face within the home, and what measures were in place to keep them safe at all times. During the inspection, we observed people were supported with their mobility by using equipment which included a wheelchair and walking frame. We observed care workers supported people with their mobility patiently and people were not rushed. There was some information about people's mobility and precautions care workers needed to take to ensure people were kept safe. However there were no appropriate risks assessments in place which detailed the risks associated with using the equipment and steps staff needed to take to ensure people were safe in areas such as transferring, repositioning and moving and handling to minimise the risk of harm to people. In one person's care plan we noted the person who sometimes used a wheelchair needed to be supported by two members of staff when walking however we observed during the inspection, this was not being followed by staff as this was being done by one member of staff. Records showed and staff confirmed they had received training on safe moving and handling practices. During the inspection, three members of staff were receiving in house training in moving and handling practices.

We recommend risk assessments are reviewed to identify all the risks people may face and implement measures to manage identified risks.

When people displayed signs of behaviour that presented a challenge, there were management guidelines which showed the triggers and signs which would cause them discomfort and the support that was required by staff to help people to feel at ease and to minimise escalation of the behaviour. Records showed the home encouraged distraction techniques to deal with behaviours that challenged such as diverting the person's attention to making a drink or prompting whether the person wanted to go to their room. When speaking to care workers, they showed awareness of people's behaviours and how they would try to make them feel at ease. One care worker told us "I will reassure them that everything is okay and try and lead them away from the area to help calm them down. We have to protect the person but we have to protect the other residents as well. It is their home too." One relative told us "The staff know [person] very well. There had been an improvement since [person] has been at the home and is much calmer. I am very pleased with that."

Records showed and care workers confirmed they had received training in managing behaviours that challenged. However when speaking to care workers, they told us the training was not sufficient and they would like to have more training as some of the people using the service displayed particular behaviours that care workers found difficult to manage. We spoke to the new manager and he told us he would review any additional training that staff could undertake and support them in this area.

There were some arrangements in place to manage the finances of people using the service. The registered manager showed us records and explained the care workers recorded all the transactions and kept the receipts which the registered manager would check on a monthly basis. However people using the service who either did not have family or had no/limited contact with their families did not have appointees, which is a person or organisation entrusted with managing the daily finances of people that may not have the capacity to do so themselves. We noted Caretech was responsible for managing people's finances but could not see how and what process had been followed that showed the decision about Caretech managing peoples finances was made in people's best interest. We spoke to the new manager and he told us that he had spoken to the finance team who advised there were long standing agreements between the provider organisation and the funding local authorities where there was no family or next of kin. However we did not see any evidence of long standing agreements at the time of the inspection and the provider was unable to provide any information which confirmed the agreements were in place.

Requires improvement

Is the service safe?

We recommend that advice is taken from a reputable source about managing people's finances in people's best interests.

The provider had taken steps to help ensure people were protected from avoidable harm and abuse. There were safeguarding and whistleblowing policies and procedures in place. Records showed and staff confirmed they undertook training in how to safeguard adults. Care workers we spoke with were able to identify different types of abuse and were aware of what action to take if they suspected abuse. They told us they would report their concerns directly to the registered manager, social services, the police and CQC. One care worker told us "We have to protect them." Care workers were also able to explain certain characteristics the person they cared for would display which would enable them to know that something was wrong or the person was not happy.

There were suitable arrangements in place to manage medicines safely and appropriately. We looked at a sample of the Medicines Administration Record (MAR) sheets and saw they had been signed with no gaps in recording when medicines were given to a person. There were arrangements in place in relation to obtaining and disposing of medicines appropriately with a local pharmaceutical company. Records showed and care workers confirmed they had received medicines training and policies and procedures were in place.

There were effective recruitment and selection procedures in place to ensure people were safe and not at risk of being supported by people who were unsuitable. We looked at the recruitment records for three care workers and found appropriate background checks for safer recruitment including enhanced criminal record checks had been undertaken to ensure staff were not barred from working with vulnerable adults. Two written references and proof of their identity and right to work in the United Kingdom had also been obtained.

We saw there were systems in place for the maintenance of the building and equipment to monitor the safety of the service. Portable Appliance Checks (PAT) had been conducted on all electrical equipment and maintenance checks. Accidents and incidents were recorded and fire drills and testing of the fire alarm completed.

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Requires improvement

Is the service effective?

Our findings

Relatives spoke positively about the staff at the home. They told us "Staff know [person] and know how to look after them", "All of them are good" and "Staff are extremely good to [person]." When speaking about a person's keyworker, one relative told us "[Care worker] is very good with [person]. Really makes an effort with him. I have confidence in [care worker] and the way they look after [person]." Another relative told us "[Care worker] is very good. Excellent for [person]. [Care worker] is really there for [person}."

At our last inspection on the 17 July 2014, we found that the arrangements were not suitable to support staff to deliver care to people using the service safely and to an appropriate standard. Appropriate training about people's complex needs was not being provided to staff. This meant the provider was in breach of regulation 23 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. At this inspection we went through the action plan and looked at the work the provider had completed.

The new manager showed us an in house communication quiz which had been recently introduced. This involved staff completing a questionnaire on a specific subject such as safeguarding to test staffs knowledge and understanding about the area and discuss further within a team meeting. Staff spoke positively about this method and told us it helped them understand things better. One care worker told us "The communication quizzes are very helpful. We have a discussion about it and that improves our understanding and we can ask questions."

Some staff training had been provided. Records showed and staff confirmed they had received in house Augmentative and Alternative Communication training which involves learning about different methods which can be used to communicate with people who are unable to communicate verbally.

However, Enabling Communication through Sensory, Intensive interaction and Engagement (ECSIE) training, planned for in the action plan had not been provided. Care workers told us they were looking forward to receiving this training as they thought it would be more relevant to the people using the service however staff had not yet attended this training. The new manager and staff told us the training had been arranged for the 17 March 2015 but it was cancelled and further information had not been received by the provider as to when the training would be made available for them.

The provider action plan set out ways in which a Behavioural Specialist was to work with the service to make sure that staff had an understanding of individual techniques and approaches. Care workers told us a behaviour Specialist who specialises in identifying communication and interaction techniques came in for a brief period of time and had shown staff how to use Makaton which is a method that uses signs and symbols to help communicate with people. However staff had not received any further sessions with the specialist.

They told us that the training was useful however not specific to the needs of all people using the service as some of them had visual impairments and could not use such methods.

The provider action plan outlined the development of further training within the service would be provided by the Behaviour Specialist, until staff and the Behaviour Specialist felt comfortable and ensured that all communication and interaction requirements has been met. As no further sessions with the specialist had been arranged, the development of such training had not been done or implemented within the service.

The provider action plan also outlined that RNIB (Royal National Institute of Blind People) training would be sourced and arranged if required however we found this had not been actioned and staff had not received this training. The training would be required as two people using the service have visual impairments.

Although some additional training had been provided for care workers to use alternative communication methods, appropriate training for staff to support people with learning disabilities particularly profound and multiple learning disabilities (PMLD) and people with a visual impairment had not been provided. When speaking to care workers, they did not feel they were supported to have the necessary knowledge and skills they needed to support people using the service effectively. Care workers told us

Requires improvement

Is the service effective?

"Caretech does not support their staff", "I have no motivation. It is only the residents that keep me going, we need more training about them and their needs, "The people here have such complex needs. We need more training to know about their individual needs" and "We need more training on how to manage challenging behaviour especially in relation to the people here."

Records showed and staff confirmed they received supervision, an induction and completed training in the basic mandatory areas such as safeguarding, infection control and challenging behaviour. However most of the training staff received was online training which staff did not feel was sufficient. One care worker told us "I don't see the point of just e-learning, we need some face to face training so we can discuss and understand the training properly."

We observed people using the service had complex needs and staff would require specialised training in not only (PMLD) but effective and alternative communication methods, managing challenging behaviour and supporting people who are visually impaired to effectively meet the needs of the people using the service. We found this was not being appropriately addressed by the provider. During this inspection, although some additional training had been provided to staff, we found that staff were still not supported to enable them to carry out their roles effectively. This breach of regulation 23 was continuing and was now a breach of regulation 18 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When speaking to care workers, they showed an understanding of the Mental Capacity Act 2005 (MCA) and issues relating to gaining consent. Training records showed that all the care workers had received MCA training. One care worker told us "We always ask them and prompt them to give them choices. They will decide what they want."

There were some arrangements in place to obtain, and act in accordance with the consent of people using the service. There were no mental capacity assessments completed for people which outlined where people were able to make their choices and decisions about their care. Care plans contained some information about people's mental state, levels of comprehension and the support needed for a person in areas they may lack the capacity to give consent. Areas such as receiving medical treatment in which a person was unable to give their verbal consent, records showed the person's next of kin and healthcare professionals were involved to ensure decisions were made in the person's best interest.

However we noted for some people using the service who either did not have family or had no/limited contact with their families, it was not evident that an independent mental capacity advocate (IMCA) had been appointed or consulted to support people with decisions about their care and ensure peoples best interests were being considered and/or that people were being supported and encouraged to be involved in the decision making process as much as they able to do so. This is not in line with the MCA Code of Practice which is guidance that states what should be done when acting or making decisions on behalf of people of people who are unable to act or make those decisions for themselves. The new manager told us there was only one person in the home that currently had an independent advocate. He told us he was in the process of setting up review meetings of people's care and will ensure this would be reviewed as part of the process.

We observed people using the service were given drinks and snacks. During meal times food was freshly cooked and care workers supported and prompted people only if it was needed. We observed there was hardly any interaction from care workers whilst people ate their food. There was a weekly menu in place however it was unclear how people communicated their choices and what they would like to eat. Care workers told us they had weekly meetings with people and records showed this, however it was not evident how people who were unable to verbally communicate were supported i.e. with the use of key words, pictures to be able to express their choice of food. The new manager told us he was going to change the current system to ensure care workers supported people to make choices about their food using different communication methods which would be recorded appropriately.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes which protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. There was evidence that showed people went out and enjoyed various activities and community outings. In areas where

Is the service effective?

the person was identified at being at risk when going out in the community, we saw that if required, they were supported by staff when they went out. When speaking with care workers they showed some understanding of how people's liberties could be deprived. Care workers told us "We can't limit them in any way and we give them their rights."

The provider was aware of the Supreme Court judgement in respect of DoLS. Records showed the provider had applied for DoLS authorisations for the people using the service and were waiting for a response from the relevant local authorities. During the inspection, we noted the home had electronic keypads with codes for the front door and the downstairs door of the second unit which restricted people from leaving the home and for people living in the second unit, they were also restricted from going into the garden as people did not have the capacity to use the keypads and be aware of what the code was. We looked at people's DoLS applications and noted this had not been included in their applications and reasons why they should be subjected to this restrictive practice. The new manager told us he would look into this area and ensure it will be included when the DoLS assessments were conducted.

We recommend the provider liaise with the appropriate authorities and review MCA and DoLS practices in the home to ensure legislation and guidance are being followed appropriately.

People were supported to maintain good health and have access to healthcare services and received on going healthcare support. Each person had a Health Action Plan which outlined people's medical backgrounds, allergies, current medication and records of appointments with healthcare professionals such as GPs, dentists, psychiatrists and opticians. People's weight was being monitored. On the second day of the inspection, we saw one person using the service went to the hospital for a follow up health appointment. Relatives told us they were kept informed of any appointments and if/or people were not well. An independent advocate for one person using the service told us "Yes they do call and make sure they tell me. When [person] had to go to the hospital, the phoned me immediately."

People were supported with their nutrition and hydration needs. There was detailed information about people's eating and drinking needs. The home had also identified risks to people with particular needs with their eating and drinking. Records showed people who had difficulty with their swallowing had been referred to a Speech and Language Therapist (SALT) and specific guidelines had been drawn up which incorporated the advice given by the SALT to ensure staff were aware of what they needed to do with peoples food such ensuring the food was mashed or included extra sauce to enable people to swallow with ease. For one person we noted sometimes refused to eat or had limited food. We saw in their care plan this risk was highlighted and there were guidelines for staff to encourage the person to have a nutritional supplement shake or soup as an alternative meal choice as advised by the SALT.

We asked the manager how they monitored what people ate to ensure they had a healthy and balanced diet. The manager showed us a record was made on a daily basis outlining what people had eaten and drank throughout each day and evening. However records did not show how people's nutritional needs were being monitored to ensure a balanced diet that promoted healthy eating and fresh food. The new manager told us he would ensure this is reviewed.

Requires improvement

Is the service caring?

Our findings

Relatives spoke positively about the service. They told us "We are very pleased with the way [person] is being cared for, I am very pleased [person] being at this home", "They are kind and [person] is happy", "I am happy with their care and happy [person] is there" and "I am quite impressed, they are caring. The home is good and it's clean."

At our last inspection on the 17 July 2014 we found people were not well supported with their communication needs and there were no guidance to help staff communicate with a person who was unable to speak. During this inspection, we found that each person had a comprehensive communication profile which detailed how they were able to communicate. The communication profiles listed specific body language, gestures and key words a person used to communicate. The communication profiles also detailed guidelines on what a person would say or do if they were happy, sad, in pain, hungry, thirsty and if they agreed or disagreed. When speaking with care workers, they were knowledgeable about people's personal and individual needs. One care worker told us "We use key words and they can understand." Throughout the inspection, we observed care workers communicated with people in a way that was understood by them.

However it was not evident how people using the service were supported to express their views and be involved in making decisions about their care, support and choices of food where possible. Records showed there were one to one meetings between people using the service and their keyworkers however it was not clear how people communicated what was recorded on the sheet. Records did not show what methods of communication were being used to engage people such as pictures, gestures, sign language and key words.

We looked at people's care plans and for people who had no/limited contact with their families and it was not evident how people were being supported to be involved in the planning of their care. Care plans had not been signed by people using the service and there was no information about the attempts that had been made to support them and involve an IMCA in the assessment of their needs and care planning. The new manager told us he would review this and ensure how people were supported to make decisions and express their choices was recorded appropriately.

We recommend arrangements for how people express their views and are actively involved in making decisions are reviewed.

Care plans set out how people should be supported to promote their independence and highlighted areas in which people were able to do things independently and where they needed support. When speaking to care workers they had a good understanding of ensuring people's independence was maintained. One care worker told us "We always encourage them to do as much as they can, with personal care for example we just prompt but they dress themselves."

However, we saw limited interaction and encouragement for people to do things independently and be involved with things such as making their own drinks or helping with meals. There was only one instance we observed where one person using the service brought out the table placemats when lunch was being prepared. One relative told us "Sometimes [person's] clothes can be in a right state. Sorting out their clothes can be something [person] can do with a member of staff. That would be good for [person. And [person] would love to be involved with things such as making their own tea but this is not encouraged."

During the inspection, we observed people did not receive person centred care. For example, throughout the day people using the service were sitting around in the home doing nothing, care workers were not engaging people in a meaningful manner and did not spend any quality time with people. Care workers were more task focused which means care workers were more focused on household chores and tasks relating to their work rather than spending quality time with people, engaging and involving them in meaningful activities. One relative told us if staff are available, it would be nice if they could spend more time with [person] as [person] likes speaking with staff."

People were given food and drink at set times during the days and we observed this was also reflected in the attitude of care workers. For example, one person indicated that they wanted a drink and the care worker told us "[Person] has already had one." This would have meant the person who was thirsty would not have had the drink they wished for.

People were relaxed and were free to come and go as they pleased in the home. Care workers were patient when supporting people and we observed people were

Requires improvement

Is the service caring?

comfortable with the care workers. During the inspection we observed when a person wished to rest in their room, this was respected and accommodated for. Care workers kept doors closed and knocked when entering people's rooms.

We saw people being treated with respect and dignity. When speaking to care workers, they had a good understanding and were aware of the importance of treating people with respect and dignity and respecting their privacy. Care workers told us "We make sure the doors are shut and they have a towel around them or a dressing gown" and "When I give [person] personal care, I always ensure I speak with them and explain step by step what I'm doing or going to do." Care workers told us that there were people using the service who only wanted female care workers to provide them with personal care and they ensured that this was adhered to. When speaking to the male care workers, they showed a good understanding and consideration to this. Relatives told us "[Person's] clothes are spotless and their room is clean" and "[Person] is happy and always well dressed. They shave [person] every day and take them to the barbers to get their hair cut."

For people who had contact with their families, meetings were taking place between the person using the service, their keyworker, registered manager and family where aspects of people's care were discussed and any changes actioned if required. When speaking to relatives, they confirmed review meetings did take place. "Yes we have the review meetings and looked at the care plans", "Yes we have had an annual review meeting. They discuss everything about the care. They ask [person] and involve [person] as well" and "Yes there have been a few review meetings but we review the care and we are not informed of the next steps or if things have been followed up." An independent advocate for one person using the service told us "Yes we have review meetings and have seen the care plans. I have a review meeting with the new manager next week. Due to personal reasons I am not able to travel to the home as often and requested whether [person] could come and see me and they have accommodated this for [person] so our meetings are still done on a regular basis."

Requires improvement

Is the service responsive?

Our findings

When speaking about the service, relatives told us "They are very good, they listen" and "They are very co-operative, they care about [person]. This is the best home for [person]."

At our last inspection on the 17 July 2014, we found the provider did not plan and deliver care in a way to meet a person's individual needs through the provision of meaningful activities. This meant the provider was in breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. At this inspection we went through the action plan and looked at the work the provider had completed.

Since the last inspection, we found all the people using the service were now attending a day centre where they engaged in activities and were out in the community during particular days of the week. During this inspection some people attended a day centre, two people were taken out into the community for some lunch and one person was being taken by their relative to get a massage. Some people using the service had been allocated a specific amount of hours per week for one to one support to go out in the community or visit the day centre. When speaking about a keyworker, one relative told us "[Care worker] is very good. [Care worker] is very keen for [person] to do activities and encourages [person] to do so. [Care worker] is very patient with [person]

Provisions had also been made for people using the service who were visually impaired to attend a day centre for one day during the week. The new manager told us they would be requesting more days during the week for them to attend as people tended to enjoy their time at the day centre.

However it was still not evident how peoples care and treatment was appropriate and met their needs. Individual activity planners which identified people's choice of activity on a daily basis, as planned for in the provider action plan, had not been developed. They had an activity timetable for the week however terms such as 'Choice of activity' had been used and the guide did not specifically state what activity the person had been engaged with or will be engaged with during the week. Neither was there any evidence to demonstrate that activities were being monitored to ensure that the activities people were engaged with were meaningful or that they had been conducted. It was also not evident how the service supported people to communicate their choice of activity as people lacked capacity and were not able to communicate verbally. Feedback from care workers indicated that some one to one support was not being achieved with people due to the lack of staff in the home. The home did have an activities room which contained games and puzzles however it was not in use for people using the service and neither were people being encouraged to use it.

People's care plans contained limited information about people's specific interests. We noted in some care plans, it stated people liked nail painting, magazines, games and reflexology music but it was not evident that the home had made any attempt for people to be able to engage with these activities in the home.

The treatment received by people was not appropriate and did not meet their needs. The provider action plan set out ways in which objects of references and pictures cards would be used with people using the service to ensure people understood what activity was about to happen and that the activity was tailored to people's needs. However, throughout the inspection, we observed objects of reference and pictures cards were not been used by any member of staff to communicate or engage with people using the service who lacked capacity and were not able to verbally communicate.

For the two people using the service who had visual impairments, it was not evident that any other reasonable adjustments had been made in the home in response to their visual and mobility needs such as sensory equipment, extra lighting, a contrasting colour scheme or hand rails around the home so people could navigate and be familiar with their surrounding environment. When speaking to care workers, they were aware of the people's personal needs but not aware of how to support a person with a visual impairment.

During this inspection, we found there were still significant periods throughout the day where people were left on their own and doing nothing as observed at our last inspection on the 17 July 2014 which reduced the quality of life

Requires improvement

Is the service responsive?

experienced by people using the service. There was little interaction from care workers who did not engage with people or involve them in meaningful conversation, daily living tasks or activities. Care workers tended to be busier with chores around the home and cooking meals and did not have the time to sit and spend quality time with people using the service. This was reflected during our own observations and feedback from staff. We saw one person who we observed from the last inspection was engaged in the same game and was sitting in the same chair as observed in the previous inspection. We were told this was a game that the person enjoyed however it was not evident that the person had been offered any alternative activities to choose from or that staff had the time to sit with the person and play the game with them. The game was designed for two players.

Although some action had been taken by the provider, people were still not receiving person centred care that was appropriate to their needs. People using the service were still not in engaged in meaningful activities. This breach of regulation 9 was continuing and was now a breach of regulation 9 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to visit family and friends or receive visitors and were supported and encouraged with maintaining relationships with family members. Relatives told us they often visited people using the service and people were supported to come and stay with their relatives at the weekends. They told us staff in the home would drop the person off at their home and pick them up. One relative told us "[Person] is always ready and happy to be going back to the home when staff come to pick them up." Another relative told us "When I speak to the new manager, he has responded immediately. For example, I mentioned that [person] needed extra pillows. When I visited the home, two new extra pillows had been provided for [person]."

On the day of the inspection, a relative came to take a person using the service to get a massage. We observed staff welcomed the family member and their time spent in the home was not rushed or interrupted. The relative told us "The staff are very good and very friendly. They have a laugh and joke with [person]. There needs to better communication amongst staff though. I came and they weren't aware I was coming and [person] wasn't even ready to go."

We looked at four care plans which contained information such as the person's habits, daily routine, what they liked for breakfast and preferred times they liked to wake up and go to sleep. The care plans showed how people communicated and encouraged people's independence and provided prompts for staff to enable people to do tasks by themselves. Care plans also contained guidelines for night staff to follow and what to do if people woke up during the night and checks needed to ensure people were safe and any personal care they may need. When speaking with care workers, they were able to tell us about each person's personal and individual needs. We saw care plans had been reviewed and updated. The manager told us since he joined the home, he had been in the process of re writing and updating the care plans and was still in process of doing so.

There were procedures for receiving, handling and responding to comments and complaints which also made reference to contacting the Local Government Ombudsman and CQC if people felt their complaints had not been handled appropriately. There were no recorded complaints received about the service. Relatives we spoke with had no complaints or concerns about the service. An independent advocate for one person using the service told us "I had some concerns about a particular care worker some time ago and they dealt with this straight away."

Requires improvement

Is the service well-led?

Our findings

The service was not well led. Since the last inspection the previous registered manager had left the service and staff told us there had been numerous changes with staff. Although a new manager had been appointed there were issues with staffing levels and the service was relying on bank and agency staff and permanent staff were not being supported. There was a lack of consistency in the care being provided and familiarity to people using the service. One care worker told us "It's all too confusing. We need a consistent manager and we need to know what our direction is."

Since the last inspection the provider had implemented some measures to address the concerns identified during our previous inspection on the 17 July 2014 as outlined in their action plan. However they had not been followed up such as the additional training which staff were still waiting to receive and the possibility of any further use of the behaviour specialist. Neither had this been monitored to evaluate the effectiveness of such measures. There were still outstanding issues with supporting and developing staff to enable them to support people effectively and to ensure the service responded to people's needs and people were engaged with meaningful activities and developed their daily living skills. The care and support being provided to people using the service was task focused which meant care workers were more focused on household chores and tasks relating to their work rather than spending quality time with people, engaging and involving them in meaningful conversation and activities. It was not evident how the service gained consent from people who lacked capacity and had limited/no contact with family and how they supported them with planning and making decisions about their care. As a result of this, further breaches have been found during this inspection.

Records showed an audit had been conducted by the provider for April and May which covered aspects of the service such as health and safety, medication, staff supervisions and staffing. We noted the audit contained comments such as "Staff appear to be very task focused", "…..very few activities" and "Service users are supported to make their own decisions and choices, although mentality can be a little institutional from staff". The auditor goes on to state they had spoken to the previous and the new manager about these issues however there was no actions recorded by the provider which showed how they would address these issues and what measures would be place to drive improvement. Although staffing was looked at during this audit, it was not evident that the issues with staffing levels had been identified.

This demonstrated systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. During this inspection, there was insufficient evidence to demonstrate that the provider had addressed the concerns raised at the last inspection and improvements had been made to the quality of care being provided to people.

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

A new manager had been appointed who had been in post for three months. The assistance he could provide with the inspection was limited as he had not been in post for long and theaction plan had been written by the previous registered manager who has now left the service. It was not evident that the provider or the senior management had taken appropriate action since the last inspection so issues could be followed up or what the level of support that was currently being provided to the new manager to ensure the regulations were being met. The new manager told us he was aware of the issues raised at the last inspection. He told us since he joined the service he was getting to know the people using the service and re writing the care plans. He was also in the process of arranging review meetings with family members. He told us he was looking into areas where the service could be improved and was producing an action plan which he wants to implement to ensure the quality of service improved and any concerns raised were addressed.

Relatives spoke positively about the new manager and told us "[Person] is happy with him. He is much kinder. I am very impressed, he is professional. Things seem to under control". "I have spoken with the new manager and he is a nice person, [new manager] is open and accessible and easy to talk to. He is responding to things as quickly as he can" and "The new manager is making quite a difference. I am very pleased about that". Care workers also spoke positively about the new manager and told us "Yes he is approachable and listens to your concerns", "The new

Requires improvement

Is the service well-led?

manager is experienced and is taking things to the next level and the right direction" and "He is very good. Any problems you can go to him and he gets on well with the staff."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient numbers of suitable staff deployed to keep people safe and meet their needs** Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people.** Regulation 17(1) (2) (a) (b) (f)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Care workers were not supported to have the necessary knowledge and skills they needed to carry out their roles and responsibilities Regulation 18 (2) (a)

The enforcement action we took:
A warning notice has been served.
The provider is required to become compliant with Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 1 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not plan and deliver care in a way to meet a person's individual needs through the provision of meaningful activities. People using the service did not receive care and treatment appropriate to their needs. Regulation 9 (1) (a) (b)

The enforcement action we took:
A warning notice has been served.
The provider is required to become compliant with Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 1 September 2015