Elite Care Homes Ltd

Moseley Gardens

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 29 and 30 November 2017. This was an unannounced inspection.

Moseley Gardens provides accommodation and personal care for up to eight people who require specialist support relating to their learning disabilities and/or mental health needs. At the time of our inspection, there were six people living at the home. At the last inspection that service was rated as requires improvement; sufficient improvements had not been made and a further deterioration was noted.

The provider was required to deploy a Registered Manager to manage the service as part of the conditions of their registration. There had not been a registered manager in post since August 2017. The provider had appointed a new manager who had been managing the day to day running of the service since October 2017 and they were applying for their registration with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not always safe because the provider had not always ensured that there were sufficient numbers of staff available to meet peoples' needs in a safe way both in and outside of the home. Staff were not always aware of people's personal histories and therefore were not aware of some of the risks associated with their support needs. This meant that people, staff, visitors and the general public were put at risk of actual or potential avoidable harm. The home environment did not always promote comfort or safety; it was not always clean or well-maintained. The provider's quality monitoring systems and processes had been ineffective in identifying some of the shortfalls found during the inspection. Where quality assurance processes had identified areas in need of improvement, the provider had not always responded efficiently to ensure the safety and quality of the service was maintained in a timely manner.

Staff received training relevant to their role but it was not always evident how they transferred their learning in to practice. People were not always cared for in the least restrictive ways possible and the provider was not always responsive to their feedback. This meant that people's views and opinions were not always listened to or valued and people were not consistently treated with dignity and respect.

The provider did not use communication aids to enable people to fully engage within the planning or review of their care or to influence the development of the service. People were supported to engage in some activities of interest but there were missed opportunities by staff to interact with people in a meaningful way. This meant that care was not always provided in keeping with quality standards set for services that support people with learning disabilities.

People were supported to maintain good health because the provider worked collaboratively with other agencies. However, this was not always by way of a proactive approach. People were encouraged to develop and maintain their independence as far as reasonably possible and were supported to sustain relationships

with people that were important to them. Visitors were welcome at any time.

This meant we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; regulation 12 associated with safe care and treatment and regulation 17 concerning the governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement has been made within this timeframe and we continue to find a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months of our return visit if they do not improve. After which, this service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will then be conducted within a further six months, and if there is still not enough improvement and an on-going rating of inadequate is awarded for any key question or overall, we will take further action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risk management plans, staffing levels and communication systems did not always promote the safety of people, staff, visitors and the wider public both in and outside of the home.

People were not always supported to live in a safe and comfortable home environment.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People received their prescribed medicines when they required them.

Is the service effective?

Requires Improvement

The service was not always effective

People's rights were not always protected because communication systems and staff practices did not always ensure care was provided in the least restrictive ways possible.

People received care from staff who had received the relevant training to their job role but they had not always transferred their learning in to practice.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary, although this was often in a reactive rather than proactive approach.

Is the service caring?

Inadequate

The service was not always caring.

People's needs were not always met in a safe way and the provider had not ensured that people were cared for in a comfortable environment.

People were not always cared for in a respectful or dignified way. The home environment showed that staff did not always advocate for people's comfort and the provider had failed to listen and respond to people's feedback.

People were encouraged to be as independent as possible.

Is the service responsive?

Inadequate

The service was not always responsive.

Some people were supported to engage in activities of interest but there were missed opportunities by staff to interact with people in a meaningful way.

There was some evidence to show that people were involved in the planning of their care but the provider had failed to utilise communication aids to optimise people's involvement.

People were supported to maintain positive relationships with their friends and relatives.

Is the service well-led?

Inadequate

The provider was not meeting the conditions of their registration because they had not ensured that there was a registered manager in post.

The systems and processes in place to assess and monitor the safety and quality of the service were not always effective. Where shortfalls had been identified, the provider had not always rectified these issues in a timely manner.

The new manager was open and honest in their communications with us and recognised the failings identified during the inspection.

Moseley Gardens

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 29 and 30 November 2017. The inspection was conducted by two inspectors. We carried out this inspection because we had received some information of concern regarding a number of safeguarding incidents that had occurred within the home.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We did not receive the PIR until after the inspection site visit and therefore could not use this to inform our inspection plans. We looked at the information that we hold about the service prior to visiting the home. This included statutory notifications from the provider that they are required to send to us by law about events that occur at the home, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we spoke or spent time with five of the people who lived at the home. We also attempted contact with four people's relatives and managed to speak with one. We spoke with five members of staff including the manager, a shift leader, two care assistants and an agency worker. Some of the people living at the home had complex care needs and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us. We also made general observations around the home and reviewed the care records of three people to see how their care was planned. We also looked at the medicine administration processes within the home. Furthermore, we reviewed training records for staff and at two staff files to check the provider's recruitment

and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that improvements were required to the safety of the service because there was a lack of organisation around the deployment of staff. This meant that staff were reactive to incidents that occurred within the home rather than proactively responding to people's care needs and managing any associated risks. During this inspection, we found that improvements had not been made.

When we arrived at the home, we found three members of staff were available to support five people and a fourth staff member was supporting another person outside of the home. One of the people living at the home required one to one support from staff. This meant that two staff were available to support the remaining four people within the home; these staff members were also responsible for domestic tasks including cooking and cleaning. We found that one person required two members of staff to support them with their personal care, whilst others required one to one support and supervision whilst engaging in other activities such as drink and meal preparations. Observations we made showed that staff were stretched to meet the varying needs and requirements of people safely and to attend to the domestic tasks required of them. A relative we spoke with confirmed that this was also their experience when visiting their loved one within the home. They said, "I think they [provider] could do with more staff; when I have been there [at the home] I have seen them [staff] running around everywhere".

People, relatives and staff we spoke with told us that the people living at the home enjoyed going out. We heard people asking staff to go for walks, to go to the local shops or to go to the nearby pub. Staff explained that they tried their best to accommodate peoples request to go out as best they could but it was difficult at times due to the staffing levels within the home. We saw that some people did get to go out with the support of staff, but this was not always risk assessed appropriately or facilitated in accordance with people's risk management plans. Care records we looked at showed that some of the people living at the home had been assessed to pose as a potential risk to themselves, staff and to the wider public both in and outside of the home and therefore would benefit from the supervision and support of two members of staff. However, staffing levels in the home did not facilitate this level of support. We also saw that risk assessments indicated that the staffing levels required to support a person outside of the home were to be determined upon their mood and mental state prior to leaving. Relatives and staff we spoke with as well as records we looked at showed that people's behaviour could often be 'un-predictable'. Where incidents had occurred, changes to the staffing levels or risk management plans had not been implemented.

Records we looked at also showed that where incidents had occurred within the home, including episodes of physical aggression, preceding factors identified as contributing to the incident were repeatedly recorded as 'staff need to be more vigilant'. It was evident from our observations that staff were often too distracted by people's varying requests for support, or with other tasks to enable them to pay their full attention to proactively prevent such incidents. For example, we saw a person who was receiving one to one supervision, fell off the sofa a banged their head, whilst the staff member was talking to another person who lived at the home. This showed that where analysis of incidents had occurred, the provider had failed to take the appropriate action to mitigate further incidents and to demonstrate that lessons had been learned.

When we first arrived at the home we spoke with the shift leader. We repeatedly asked them whether there were any risks or personal safety issues that we needed to be aware of. We were told about two people who sometimes presented with behaviours that the staff found challenging, including physical aggression but otherwise, there were no other concerns to be aware of. However, when we looked other people's care records we found that they too also presented with a number of significant risks that should have been shared with us. For example, we found that one person was known to become particularly anxious around health professionals which could result in physical aggression. This person's risk management plan stated that visiting professionals should be made aware of this risk and be advised to remove any lanyards or name badges to ease the distress for this person but also for their own personal safety. This was not shared with us when we first arrived and we readily engaged with this person without understanding their anxieties or any associated risks.

Other risks associated with people's personal histories, including their forensic backgrounds, which should have been shared with us as part of their risk management plans, were not. This was because none of the care staff we spoke with were aware of significant risks associated with people's backgrounds. Staff told us that they didn't have time to read people's care plans or risk assessment and that they relied upon information being handed over to them. This meant that communication systems within the home had failed to ensure that staff had the information they needed in order to protect the safety of the people they were caring for as well as themselves, visitors and the wider public.

Observations we made around the home showed that the maintenance and cleanliness of the building required improvement, in order to protect the safety and to promote people's comfort within their home environment. We saw en-suite facilities that had a substantial build-up of mould and mildew, a clinical waste bin that needed emptying and had a strong smell of faeces within a person's bedroom and a light bulb that needed replacing so that one person was not expected to shower or to use the toilet in the dark. People's bathrooms did not always have a supply of toilet roll and furniture within the home was in state of disrepair and required replacing, including the flooring in the dining room and the dining chairs. One person living at the home often spent time on the floor. We saw that some of the beading around the laminate flooring in their bedroom needed replacing because nails were exposed. We also found two hair grips on this person's bedroom floor. Staff we spoke with were unable to explain how these had got there other than to say that they must belong to a member of staff. The manager of the home recognised that this posed a risk to this person's safety given that they had a tendency to put things in their mouth and they were also known to be at high risk of choking. Furthermore, this person was at risk of falling out of bed and required a falls sensor mat. This is a piece of equipment that is used to alert staff to provide support to people when they attempt to get out of bed or indeed if they had experienced a fall. Staff we spoke with were aware that this person needed this equipment but told us that 'it had not been used for a long time'. One member of staff said, "It's [mat] in his room, but it doesn't work because they [staff] can't find the plug for it". We saw that the mat had been pushed under the person's bed and was not being used because there was no plug adaptor for it. We asked to see the maintenance book to check whether this had been reported but this could not be found at the time of our inspection. The manager told us that they were unaware of the fault. Therefore this had not been replaced and staff did not have appropriate equipment to mitigate the risk to this person.

We looked at other records concerning the safety and maintenance of the building including environmental audits and fire safety. We saw that some fire safety checks had not been maintained. The manager told us that fire safety checks, tests and drills had not been conducted for some time. Records we looked at showed that the most recent fire drill was dated 25 October 2016 and the latest fire alarm system check was dated 16 October 2017. This fell outside of the providers monthly requirements. The manager explained that they had noticed a fault with the fire system panel a week before the inspection which had triggered their enquiries in to fire safety within the home. As a result, they had a meeting scheduled with a fire officer on the day of our

inspection.
All of the evidence presented above demonstrated that the registered provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they were failing to do all that was reasonably practical to mitigate risks to people's health and safety.
Despite consistency and/or lack of fire safety checks, staff we spoke with were aware of the fire evacuation policies and procedures within the home and were able to tell us where the assembly points were and how they would support people in the event of a fire. We saw that a recent fire risk assessment had been completed within the home and people had personal emergency evacuation plans which detailed the level of support they required to safely evacuate the building, which reflected what staff had told us.

At the time of our last inspection we found that serious incidents within the home were not always being recognised as potential safeguarding concerns and therefore were not always being reported to the appropriate agencies. Information we hold about the service showed that since our last inspection, we had received a number of notifications from the provider concerning either serious injuries or safeguarding concerns. Where these had been investigated by the local authority, concerns (similar to those that had been raised by staff previously and alerted to the manager of the service) were shared with us. These included concerns about people who were physically frail were particularly vulnerable to physical and verbal aggression whilst living alongside people who were very physically able. Despite a further pattern of incidents, the provider had not proactively sought advice or support from the relevant agencies or independently identified the need to re-assess the suitability of this person's placement within the home, in order to keep them safe. This demonstrated that the provider had not learned any lessons from the feedback provided at our last inspection.

Staff we spoke with were familiar with the systems and processes in place to protect people from the risk of abuse and avoidable harm. All of the staff we spoke with were able to tell us the signs and symptoms they would look out for to indicate that someone may be at risk of abuse or avoidable harm. One member of staff said, "I don't have any concerns about that [abuse] here. If I did I would report it straight away to [manager] or I can whistle-blow if I needed to too". Whistle blowing is the term used when someone who works in or for an organisation raises a concern about malpractice or wrongdoing; staff should be supported to raise their concerns within the organisation without fear of reprisal.

People and relatives we spoke with told us that they felt people were safe living at the home. One person said, "Yes, I am safe, the staff look after me". A relative we spoke with told us, "I have no concerns now; I did last year as [person] got out because the door wasn't secure but this was sorted straight away". Staff we spoke with were able to tell us how they would support someone in the event of a medical emergency such as a fall, head injury or choking. Training records showed that staff received training in first aid and had applied this training where necessary, when required. Records also showed that staff had sought medical advice and/or assistance from emergency services appropriately.

Everyone we spoke with told us they received their medicines when they needed them. One person we spoke with said, "They [staff] are good; I can have my medicine when I need it". Another person said, "Yes, they [staff] get them [medicines] for me". We saw that medicines were administered to people safely and where possible, people were given choices about whether or not they wished to take medicines that were prescribed on an as required basis, for example, for pain relief. We found that protocols were in place for medicines that were prescribed in this way. Staff we spoke with also knew how and when to administer these medicines when people were unable to ask for them. Staff told us that they had received training in the safe handling of medicines. Medicine administration records had been completed to confirm that people had received their medicines as prescribed. Medicines were stored securely in a locked trolley or cabinet which were secured to the wall.

We found that the provider had recruitment procedures in place for both permanent and agency members of staff. This ensured that only staff that were trained and checked for their suitability to work with people were deployed to work within the service. Staff we spoke with confirmed that recruitment checks were carried out before they started work. These checks included verification of their identity, previous work practices and the disclosure and barring service. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care.

Requires Improvement

Is the service effective?

Our findings

We found that people were not always cared for in the least restrictive ways possible. 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. One person we spoke with told us that they were not allowed to drink coffee as much anymore because the Doctor had said so. When this person asked staff for a cup of coffee, they were told that it was 'not yet time' for them to have a coffee. We asked a member of staff about this decision and were directed to a notice board in a communal area that stated the time that the person was next allowed a cup of coffee. Staff we spoke with told us that this person was restricted to two cups of coffee a day on medical grounds. However, there was nothing in this persons care plan to show where this recommendation had been made or by whom, or that a best interest's decision had been made concerning this decision. We asked the manager about this practice and were told that staff should not be denying this person a cup of coffee but instead to offer de-caffeinated coffee as an anxiety management strategy. We also saw this person asked a member of staff for a cigar. Staff told us that this person was limited to a certain number of cigars each day and that staff had been told to only buy this person the small thin cigars rather than the ones they preferred to smoke. Whilst we acknowledged that this was considered to be in the persons best interests with regards to health promotion and smoking cessation; there was no evidence to show that a capacity assessment had been facilitated with this person to ascertain their abilities to make this decision independently, nor did we see a best interest decision or care plan outlining the restrictions around their smoking habits.

Another person had limited access to their wardrobe because it was kept locked. This restricted their autonomy and independence within their bedroom. The manager was unable to tell us why this person's wardrobe was kept locked. This person went to ask a member of staff for the keys to open the wardrobe and was given the keys to gain access independently. On this occasion inspectors and the manager were present and observed the person to open the wardrobe but it was unclear as to why, if this person was able to have access to the keys unsupervised, were they not allowed to have access to the wardrobe at all times. It transpired that there were some items that were considered high risk within the wardrobe. However, a least restrictive approach had not been considered by only limiting access to high risk items.

We saw that mental capacity assessments and best interest's decisions had been made to support people with more complex decisions such as finances. Some people also had access to advocacy services. An advocate sees to ensure that people, particularly those that are most vulnerable in society are able to have their voice heard on issues that are important to them and defend and safeguard people's human rights. They ensure that people's views and wishes are genuinely considered when decisions are being made about their lives. We also saw that staff offered people some day to day choices regarding their preferences for things such as what they wanted to eat, drink or do. However, this was inconsistent. For example, we were told that one person communicated their preferences with their body language which staff were familiar with. When the person put their head down on the sofa or offered out their arm, this was an indication that they wanted to move. However, some staff did not respond to these gestures and the person was not

supported to leave the lounge area. One member of staff told us, "People should be given choices, by talking to them, asking them what they want, never pressuring them in to a decision and allowing them to make their own choices, but there seems to be lots of restrictions here and not all staff are familiar with the five principles of the MCA". We had also received information of concern that detailed how staff would often 'persuade' or 'coerce' a person to do something that they did not want to do, by way of offering a positive reinforcement. We were told that this inevitably resulted in incidents of verbal or physical aggression because staff had not respected the person's liberty or choices or recognised these as potential triggers for what was termed 'risk behaviours'. We discussed this with the manager who explained that some people living at the home do require support, prompting and encouragement to engage in activities that enables them to live fulfilling lives. They stated, "We are working with staff to ensure they make the right use of language when prompting and encouraging them to engage in meaningful activities".

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Information we hold showed that notifications had been submitted to us to advise that all of the people living at the home were subject to a DoLS authorisation. The manager confirmed this but stated that they had not got any of the relevant documents or paperwork as this had not been handed over to them by their predecessor. This meant that they were unaware of the expiry dates and whether any conditions had been imposed as part of the authorisations, and if so whether these were being met. During the inspection, the manager contacted the local authority to request that this information was re-sent to them.

It was evident when speaking to the manager that they had an understanding of the Mental Capacity Act 2005 (MCA) and their associated responsibilities. They told us that they planned to ensure improvements were made in this area. Records we looked at and staff we spoke with confirmed that they had received training in MCA and DoLS; however there was clearly a lack of understanding and/or application in practice given the restrictive and inconsistent practices we observed. The manager said, "I feel saddened that the words 'institutionalised practice' have been used to describe the care that is being given within a service that I am attached to; it is not acceptable and we need to be advocating better to protect the rights of people here. This is definitely something I feel emotionally and ethically bound to improve".

Collectively, this demonstrated a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were complimentary of the food that staff prepared for them. One person said, "It's [food] good". Another person said, "[food] is nice". We saw some people were supported by staff to prepare light snacks and drinks throughout the day and main meals were prepared by staff. Staff told us that they encouraged people to be as independent as possible within the kitchen and staff supervised this to promote people's safety. There was a flexible approach to meal times within the service. People were informed when food was ready and were given the choice of when and where they wanted to eat. Some people ate at the dining table, others were supported to eat in the lounge area and some people ate out. We also saw that some people chose to eat later in the day. Records we looked at showed that peoples nutritional needs had been assessed and referrals had been made to the relevant professionals where required. Where recommendations had been made, we saw that these were catered for and people received the support and assistance they required to eat. However, we did not see any menu's and could not see how people were supported to make meal choices. We discussed the benefits of having menu options available to people in different formats to support people to be more involved in meal planning and making choices.

Staff we spoke with had some understanding and awareness of the Equality Act and what this meant in practice. For example, we were told that some people required a culturally specific diet and this was catered for. However, one member of staff we spoke with told us that this was not always considered for everyone living at the home. They gave an example of how some specific cultural diets were catered for but this often restricted other people's food choices. They stated, "Other people's diets are catered for, so why should [person] be restricted because of that? [Person] is a white British person who should be able to have sausages and bacon; I cooked it for him the other week and he loved it. They [staff] say he has a small appetite but I think they [staff] are just not giving him foods he enjoys; he always seems hungry to me". We found that the provider explored and supported people to express their sexuality and any associated needs by way of planning this as a part of their care and liaising with other agencies, as required. People were also supported to access other support agencies that could enable them to access community services and activities of interest without discrimination. This included seeking voluntary work or attending college courses, day centres or planned activity groups.

We found that people living at the home had access to doctors and other health and social care professionals. People, relatives and visiting professionals we spoke with and records we looked at showed that people were supported to maintain contact with external agencies involved in monitoring and supporting their health and well-being, including specialist learning disability and mental health services. However, communication systems both within the service and with external agencies were not always effective to ensure people received the care and support they required. We found that some referrals to specialist services were a reactive rather than proactive response by the provider and they had not always independently identified when a person's care needs required a review. It was also evident that communication systems within the home had failed to ensure staff had all of the information they needed to support people safely.

Staff we spoke with and records we looked at confirmed that staff received training that was relevant to their job roles. People and relatives we spoke with were confident that staff had the knowledge and skills they required to care for people safely and effectively. However, observations we made and issues we identified throughout the inspection showed us that staff were not always transferring their learning in to practice. We reflected this back to the manager. They told us that more investment was needed in staff learning and development opportunities. They said, "We recently invested in MAPA (the management of actual and potential aggression) training which was face to face learning. You could see the enthusiasm and engagement of the staff; it showed that staff responded to practical, face to face sessions much more and it was good to see. We need to use this as a benchmark moving forward and I have shared this with the provider".

We found that staff meetings had recently been reinstated and the manager was aware that many staff members had not received supervision for a long while. Dates we looked at showed that one member of staff had not received supervision since October 2016. Supervision is typically a one to one meeting between a manager (or a senior) and a staff member. Its purpose is to provide a safe, supportive opportunity for staff to engage in critical reflection in order to raise issues, explore problems, and discover new ways of handling situations or issues within the workplace. It is also an opportunity to discuss learning and development opportunities and for managers to oversee staffs work practices. The manager recognised that they needed greater oversight of the practical skills and competencies of staff and the working practices which were contributing to the culture of the home. They planned to spend more time in the communal areas, leading by example, whilst also facilitating observed practices and spot checks.

Inadequate

Is the service caring?

Our findings

The providers systems, processes and oversight of the home were not sufficient or effective and did not ensure that people received care that was safe, effective, responsive and well led, which meant that people were not cared for. Whilst some individual staff members were reported and observed to be caring and kind, we found that some aspects of the care being provided to people were not always caring. For example, we saw some staff members communicating with people in a way that was not always considered age-appropriate. We also did not see any communication aids available within the home to assist staff to interact with people who were unable to verbalise or with those that would benefit from additional support to understand, make choices and to engage with staff. For example, pictorial food menus, easy-read information tools or visual communication cards.

We found that since the new manager had been deployed, they had attempted to seek feedback from people living at the home and their relatives. However, where people had fed back on the service, or made request these were not always acted upon and people's voice was not heard. From records we looked at, it was also evident that the lack of communication aids and innovation meant that this was not always effective. For example, we were told that relatives were invited to attend a meeting to offer feedback on the service provided to people at Moseley Gardens but no-one turned up. The manager acknowledged that it would have been useful to try other forms of engagement such as questionnaires or telephone liaison in order to promote the involvement and source feedback from people's relatives. They said, "We are looking at introducing communication aids to support people and will think more widely about how we can involve people and their relatives more, moving forward".

The environmental issues that were identified throughout the inspection also showed that consideration had not always been given to the safety and comfort of people living at the home. This meant that they were not always treated with dignity and respect. We saw furniture and flooring that was in a state of disrepair and the condition of people's personal bathroom facilities were unacceptable. People's bedrooms were sparse and did not reflect their personalities, hobbies or interests. Two bedrooms did not have curtains. We also saw that one person's chest of drawers were broken. Records we looked at showed that this person had requested a new chest of drawers three weeks prior to the inspection and these had not been replaced. This person's en-suite facility also had no light bulb and staff spoken with were unsure how long they had been expected to shower and toilet in the dark. We fed these issues back to the manager. By the second day of our inspection visit new curtains had been hung, the light bulb was replaced and a new chest of drawers had been assembled. We reflected back to the manger how sad it was to note that a person's requests for improvements to their bedroom had seemingly been ignored for three weeks; an inspector commented and it is addressed within 24 hours. This demonstrated that people's voice was not respected by the provider. When we saw this person on the second day of our inspection they were excited to tell us that they had new curtains and new drawers, which showed how important this was to them.

People and relatives we spoke with told us they were satisfied with the care that they received at the home. One person said, "They [staff] are nice". Another person said, "I like [listed a number of staff names]". A relative told us, "[person] seems much happier there [Moseley Gardens] than anywhere else they have

been". They went on to tell us that this person referred to the service as 'home' and would return to the house without any concerns, after spending time with family. Professionals we spoke with told us that they had no issues with the staff that supported people and felt that staff did their best within the constraints of the provider. They told us that there seemed to be a discrepancy between some people's level of need and the funding packages provided. This meant the provider had not always appropriately or continuously assessed how they would meet people's needs within the funding provisions available to them which compromised the quality and safety of care. Nevertheless, we heard from one professional how, one person in particular had made significant progress since living at the home.

People's privacy and independence were promoted within the home as far as reasonably possible. We found that people were encouraged to engage in activities of daily living with the support of staff in order to develop their life skills and promote their independence. One person told us how they enjoyed preparing their own drinks and we saw staff encouraging people to do things for themselves throughout the day. Records we looked at advocated for people's privacy and staff we spoke with confirmed that, where possible, people were encouraged to tend to their own personal care needs with prompting from staff in order to protect their privacy. We also found that most people were given the autonomy to choose where they spent their time, and some people chose to spend time on their own in their bedroom which enabled them to have their own personal space and privacy.

Inadequate

Is the service responsive?

Our findings

We found that people's care plans were detailed and reflected their physical, mental, emotional and social needs. However, staff we spoke with told us that they rarely had time to read people's care plans and risk assessments. All of the staff we spoke with were unaware of some people's personal histories or care needs. For example, one person's care plan had information about what was 'important' to them which included their need to wear glasses. However, we saw that this person was not wearing their glasses. Staff we spoke with were unaware that they needed to wear glass or that they had a significant visual impairment. We also found that staff were not always aware of some peoples significant risk behaviours which meant they were at risk of potential and avoidable harm.

Staff we spoke with told us they got to know people gradually by talking to them or by observing their likes and dislikes. A relative we spoke with was confident that some staff had taken the time to get to know their loved one but acknowledged that it takes time for their relative to develop trusting relationships. They told us that the high turn-over of staff had not always supported this person to build lasting rapports with staff, but this had improved of late.

Records we looked at showed that some people had signed their care plans to demonstrate that they had had some involvement in the planning or review of their care. However, the extent of their involvement was difficult to ascertain from speaking with people and the lack of communication aids meant that the provider had not ensured that their involvement was optimised.

We saw that some people were supported to engage in activities that were meaningful to them, such as going to college, going for walks or to the local shops. We saw people accessing board games, jigsaws and looking at photos independently. One person was keen to show us pictures of their holiday to Blackpool that they enjoyed with staff and other people within the home. Staff we spoke with also told us that one person loved aeroplanes and they did their best to take him to the airport on a daily basis for him to see the planes. However, people who were unable to tell staff what they wanted to do were observed to spend a lot of time in a passive state of mind due to experiencing long periods of unstructured time. When we asked staff how this person liked to spend their time, the responses were limited to watching television and going for walks. Their care records stated that prior to moving in to Moseley Gardens, this person enjoyed a structured weekly routine which included cake baking and daily visits to the local shops to get a newspaper. One member of staff said, "I think a lot of it [behaviours that staff referred to as challenging] is due to boredom". There were missed opportunities for staff to engage with this person in meaningful activities given that the person required one to one supervision. There was no evidence of any sensory stimulation, relaxation, or meaningful interaction between this person and staff. Quality standards set for the care of people with learning disabilities state that very high rates of behaviour that challenges have been reported in services that typically offer relatively limited activities. Ensuring that people with a learning disability have planned, personalised daily activities will help to reduce rates of behaviour that challenges. This would also enhance quality of life and well-being.

People and relatives we spoke with told us that visitors were welcome at any time. One relative said, "We live

nearby which is good and we visit whenever we can; we don't need an appointment but we always ring to make sure they are home". We found that people were supported to maintain relationships with people that were important to them and also, to develop new relationships within a wider social context. The manager told us, "We try to look for new opportunities for people to socialise outside of the home but also recognise the importance of developing and sustaining positive relationships within the house". We heard how one person had an interest in meeting new people and had expressed a desire to find a girlfriend. We were told that this was something that staff were exploring further with the person and considering ways they could support this person to achieve this goal in a safe way.

People and relatives we spoke with told us that they would speak to staff or the manager if they had any complaints to raise. One person said, "I tell [manager] if I'm not happy". A relative told us that they had made a complaint previously and this was addressed by the manager at the time in a timely manner. However, they stated that the high turn-over of managers made it difficult to know who to speak to, but assured us that they would 'make it their business' to find out if they had any concerns to rise. Records we looked at showed that where complaints had been raised, some of these had been addressed by the manager. Although, when people living at the home had complained (often indirectly) or made requests, for example, for a new chest of draws and curtains, this had not always been honoured. This demonstrated that people's voice appeared was not always recognised, listened to or valued by the provider.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in January 2016 we found that the provider had not ensured that the systems and processes in place to monitor the safety and quality of the service had been operated effectively. We therefore found evidence to support a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we returned in January 2017, we found that whilst some improvements had been made, further improvements were required. At this inspection, we found that progress had not been made or sustained and further deterioration was noted. This meant that the provider had a history of requiring improvement in these areas and has demonstrated that they cannot always make or sustain the required improvements, leading to a repeated breach of regulation 17. You can see what action we have taken at the end of this report.

The provider had failed to ensure that effective communication systems were in place. This meant that staff did not always have all of the information they needed, concerning people's personal histories and support needs, in order to safeguard people, staff, visitors and the wider public against the risk of actual or potential avoidable harm.

We continued to find evidence that showed the provider's quality monitoring processes were ineffective. For example, we saw environmental audits, including premises and infection control audits that had failed to identify the shortfalls that we found during the inspection. Oversight of care records including daily observations and behaviour charts had been facilitated, but failed to recognise that they lacked detail, meaning or sufficient analysis. We saw that the new manager had recently introduced guidance for staff on completing daily observation records in a more structured and meaningful way, but further review of the effectiveness of this new process was required.

Where shortfalls had been noted via the quality monitoring processes that were in place, the provider had failed to respond and rectify the issues. For example, we found that staff had consistently reported the need for an 'electric fly zapper' for the kitchen dating back to January 2017. The provider had repeatedly been made aware of this but had failed to act upon these requests. We saw other aspects of the service which the provider had failed to maintain oversight of, such as the monitoring of fire safety practices within the home. We also found that there were other parts of the service that the provider appeared to not have any oversight of at all, such as the monitoring of the medicines fridge temperatures. Staff routinely recorded the temperature of the medicine fridge as too high. This had not been included as part of the medicines audit and there was no evidence that any action had been taken to rectify this until the new manager had arrived. We reflected these findings back to the manager. They agreed that it was not clear what the benchmark for the service had been or whether the staff that were completing these audits, knew what 'good' looked like in order to make a sound judgement. The manager confirmed that there needed to be a period of time whereby they took a lead on the quality monitoring and oversight of the service in a mentoring role to the other senior staff. They were hopeful that this would foster a positive culture within the service, where quality was integral and progressively influence the attitudes, values and behaviour of staff.

The service was required to have a registered manager in post as part of the provider's conditions of

registration. 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. There had not been a registered manager in post since August 2017. Prior to this, the service had also had two other registered managers spanning back to 2015. The provider had appointed a new manager who had been managing the day to day running of the service since October 2017 and they were applying for their registration with us. However, the registration history for this location showed that there had been an inconsistent leadership structure within the service which had had a negative impact upon the quality and safety of the service. A professional we spoke with told us, "There seems to be a leadership vacuum within the service. There has not been any consistency in the leadership for over 18 months with different manager's coming in". A relative we spoke with said, "There have been a lot of changes in the management. I don't know who the manager is at the moment. I came back off holiday and it had changed again".

Staff spoken with expressed that it had been a difficult time recently but were confident that the new manager could make a difference. One member of staff said, "It's a good home, it just needs firm management and the staff need more training. I know [manager's name] will do what it needs to get it back up to standard". Having spoken with the new manager, it was clear that they had a lot of experience, passion and a good understanding of what 'good' looks like. They were confident that with time, they would be able to have a positive influence on the service. They said, "I have noticed a change in the provider's approach. They seem more interested and are listening more to my suggestions. They are making changes; the service and staff just need consistency". They gave the examples of the improvements that had been agreed and made over night, from the first to the second day of our visit. However, they acknowledged that this was a reactive rather than proactive approach. Many of the shortfalls we identified throughout the inspection were overtly evident from superficially looking around the environment and from spending time observing staff engagement with people. Despite this, most of these issues had gone un-detected or unchallenged by the new manager. This showed that improvements were needed to the new managers independent quality monitoring practices.

The manager told us that one of their priorities was to invest in the staff learning, development and support programmes. They also wanted to discuss staff incentive initiatives with the provider as they recognised the need to maintain a consistent staffing team that were skilled and motivated. We saw the manager had a supportive leadership style and staff appeared relaxed and comfortable in their presence. We observed staff approaching the manager for advice and guidance throughout our time at the service. The manager had a clear vision of what the key values of the service should be, which included a person-centred approach to empower people to live as independently as possible whilst enjoying meaningful and fulfilling lives. They were keen to develop strategies to enable them to introduce and embed these values in to practice, but recognised that they needed to take a strategic approach to first promote the safety of the service, given the significant risk factors that we had identified throughout the course of the inspection process.

We found the manager to be open, honest and co-operative both during and following the inspection. They were receptive to feedback throughout the process and demonstrated a clear understanding of the legal requirements set out by CQC and other health and safety obligations. It was evident that they recognised the failings that we had identified and acknowledged their own shortfalls. The manager accepted that they personally should have identified these concerns and challenged the provider sooner and that lessons were to be learned. They told us they were confident that given the seriousness of our findings, that they would receive the relevant support and investment from the provider to make the required improvements.

Information we held about the service showed us that the provider had not always ensured that information

that they were legally obliged to tell us, and other external organisations, such as the local authority, was passed on. For example, the provider had failed to submit the Provider Information Return form within the stipulated timeframe. Other notifications concerning accidents, incidents and safeguarding reports had been sent. At the time of our inspection, the manager had started to work more collaboratively with other external agencies such as the local safeguarding authority, Social Services and community learning disability and mental health teams to ensure people's needs were met. However, they had not always been the driving force in forging or maintaining these links. For example, it was apparent that a recent safeguarding alert triggered referrals to other agencies such as district nurses, dieticians and further input from social services for one person who lived at the home. Concerns were shared with us to suggest that the provider's assessment criteria was not always effective in ensuring that they could reliably meet people's needs or that they had considered the compatibility of people sharing the house. One professional said, "It seems that the provider is keen to fill beds and will take on people with inadequately funded packages and are then unable to meet their needs".

Staff we spoke with explained that people were supported to access community services such as colleges and local day centres. We found that since the new manager had arrived, they had also encouraged staff to widen the scope for community engagement and had started to make links with supporting organisations relevant to the needs of people living at the home. We will continue to monitor the progress of this development at our next inspection.

All of the above shows that the provider had failed to sustain any improvements made at the time of our previous inspection and the quality and safety of the service had significantly deteriorated, so much so that the provider has been rated as inadequate in two out of the five areas that we looked at. This means that the provider has been rated as inadequate overall and has been placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as Inadequate for any of the five key questions it will no longer be in special measures.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that care was delivered in accordance with the Mental Capacity Act 2005.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risk management and communication systems were implemented effectively to keep people, staff, visitors and the wider public safe from the potential or actual risk of avoidable harm. The provider failed to maintain a safe and comfortable home environment.

The enforcement action we took:

We issued an Urgent Notice of Decision to restrict admissions in to the home and imposed conditions on to the provider's registration for this location, requiring them to review their risk management and communication systems as well as staffing levels within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes were ineffective and did not protect people from unsafe practices, poor living conditions and a poor quality of service.

The enforcement action we took:

We issued an Urgent Notice of Decision to restrict admissions in to the home and imposed conditions on to the provider's registration for this location, requiring them to review their risk management and communication systems as well as staffing levels within the home.