Prime Life Limited

Clarendon Beechlands

Inspection report

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Date of inspection visit:
14 April 2016

Date of publication:
23 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 14 & 21 April 2016.

Clarendon Beechlands provides accommodation and personal care for 18 people who have specific mental health needs. The accommodation comprises of eighteen single en-suite rooms. There were 18 people living in the service at the time of our inspection visits.

There was no registered manager when we inspected, however an acting manager had been appointed and had commenced the registration process 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.

Checks undertaken to ensure the quality and safety of service provision, were not robust which meant a number of shortfalls not being identified or addressed.
Some quality checks were in place, however these did not cover the assessment and monitoring the quality of care to ensure care plans and risk assessments were up to date.
There were not always enough support staff on duty to provide everyone with all of the support they needed. Support staff knew how to respond to documented concerns so that people were kept safe from harm; however some new people that recently moved into the home did not have all the information support staff required to keep them safe. Medicines were managed safely and background checks had been completed before new support staff were appointed.

Support staff did not always respond appropriately to people who had specific communication needs. People had been supported to eat and drink enough and they had been helped to receive the regular healthcare assistance they needed.

Support staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives.

The Care Quality Commission is required by law to monitor how registered persons apply the Deprivation of Liberty Safeguards (DoLS) under the MCA and to report on what we find. These safeguards are designed to protect people where they are not able to make decisions for themselves and it is necessary to deprive them of their liberty in order to keep them safe. The acting manager had not taken all of the necessary steps to ensure that people's legal and human rights were protected, as we could not be assured people living in the home had full capacity to make decisions.

People were spoken with by support staff respectfully; however, some support staff did not always recognise people's right to privacy and dignity. For example by knocking on doors before entering private rooms.

Support staff had consulted some people about the care they wanted to receive and had recorded the results in individual care plans. People were regularly asked about their food choices and what activities they would like to undertake. People had been consulted about the development of the service. However their care plans to guide and direct support staff on how to provide care did not always reflect person centred care or promote people's independence.

Complaints had been investigated and responded to appropriately.

Tests to ensure that the environment was safe were undertaken regularly. There was a business continuity plan to ensure the effective running of the service in an emergency. Individual evacuation plans had not been produced for all those living in the home, and were not readily available in an emergency.
We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans and assessments of potential risk were not sufficiently detailed with information to keep people safe. You can see what action we told the registered persons to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not consistently safe
Care plans and risk assessments were not fully detailed, to enable staff to provide people with safe care and a safe environment.

Staff training had not covered areas vital in keeping people safe in the home.

Staffing numbers allowed tasks to be undertaken, but not to develop people's independence.

The provider operated an effective recruitment process to protect people from unsuitable staff.

Emergency evacuation plans did not include everyone living in the home, and were not readily available for staff to use.

People received the medicines they were prescribed.

Is the service effective?

Requires Improvement

The home was not consistently effective.
Staff were not trained in areas relating to substance abuse or potential suicide.

Staff received regular opportunities to meet and discuss their work and to plan personal and professional development.

People's consent to care and treatment was not regularly sought in line with legislation and guidance.

People had plenty to eat and drink and told us they liked the food on offer.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that they thought the staff were caring.

Information was not always presented in a form that could be

understood.

People's dignity and privacy was not always upheld.

People told us they enjoyed their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff had consulted some people about the care they wanted to receive and had recorded the results in individual care plans.

People are regularly asked about their food choices and what activities they would like to undertake.

Care plans did not reflect person centred care and promote people's independence.

Complaints had been investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some quality checks were in place, however these did not cover the assessment and monitoring the quality of care to ensure these were up to date.

People who lived at the service were asked for their views about their home.

Safety tests on the environment were undertaken regularly.

There is a business continuity plan to ensure the effective running of the service in an emergency.

Clarendon Beechlands

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 registered persons were 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.

Before our inspection visits, we reviewed the information we held about the service. We also took into account the notifications of incidents that the registered person had sent us since the last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We visited the service on 14 & 21 April 2016, these were unannounced inspections. The inspection team consisted of three inspectors on day one and one inspector on day two.

During the inspection we spent time observing the care being provided throughout the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who lived at the service, two visiting relatives and two visiting health professionals. We also spoke with six support staff, the acting manager and the provider's representative. We observed how care was provided in communal areas and looked at the care records for ten of the people living in the service. In addition, we looked at records that related to how the service was managed including the staff rota, recruitment files, training and quality assurance documents.

Following the inspection visit we spoke by telephone with six relatives so that they could tell us their views about how well the service was meeting their family members' needs and wishes.

Requires Improvement

Is the service safe?

Our findings

We found that the arrangements in place to manage people's care and treatment safely were not adequate and placed people at increased risk.
We spoke with staff about some people who had recently moved into the home. When we asked the support staff about these people they were partly aware of their previous life histories and self-harm, but not about the attempts on their own life. That meant that information vital for the care and safety of people had not been passed onto the support staff.

We looked at the care plan of a person who had previously attempted to take their own life prior to their admission. We found that their risk assessment was insufficiently detailed and did not reflect the level of risk or demonstrate that the potential for future risk had been assessed. There was no recognition of the process to make the environment safe to reduce the risk involved and no awareness by support staff of any environmental risk.

On the first day of our inspection visit, we showed the provider's representative (an associate director of the company) and the acting manager, where this person's care plan lacked detailed information about the potential self-harm risk this person presented. When we returned on the second day, we found that the person had made a further attempt to take their life. Though the care plan and risk assessment had been amended it still did not include the information provided in the social work assessment. The acting manager had still not informed the support staff of this person's risks around attempts to take their own life. Support staff confirmed they had still not been told of the previous attempts this person had on taking their own life.

When assessing potential associated risks past, present and future risks should be assessed. The National Institute of Clinical Excellence (NICE) indicates that clinical and non – clinical support staff who care for people who have self – harmed, should have appropriate training and skills to equip them to deliver the necessary care for the associated risks. For example, severe overdosing, risks through lacerations to body and for people at risk of self-harm, using ligatures points. Ligature points are places to which people intent on self-harm could tie something to harm themselves. Support staff had undertaken some training in mental health, but did not have the specific training to enable them to recognise and deal with these types of emergency. This meant people may be placed at risk from a support staff group that were not fully informed.

Care plans were completed and reviewed regularly, however the information provided was not always in sufficient detail for support staff to support people safely and consistently. For example, in one person's care plan they were identified as being at risk, because they could neglect their physical health and could become anxious about attending appointments. The actions to support this person stated, "To help [Name] maintain good physical health." No details were provided for support staff to understand what they needed to do to or support this person and recognise signs that could identify that they were neglecting their physical health. Similarly there were no prompts about how to support their anxieties.

Risk assessments did not guide support staff on how to interact with people to ensure that their behaviour

did not present a risk to themselves or others. For example' one person's mental health care plan stated "[Name] can become anxious and agitated, they can become verbally and physically aggressive towards others and support staff and self-harm when mentally unwell." Another person's care plan identified that they required support for depression, hallucinations, schizophrenia and physical aggression. The care plan stated, "For appropriately trained support staff to support [Name] with his mental health related needs and to seek professional support from his mental health team should it be required." There were no further risk assessments completed or actions for support staff to take to support these people which could place the individual, other people in the home and support staff at risk of harm if their behaviour was not managed.

One person told us, that they did not always feel safe in the home because of people shouting. They continued to say, "Support staff aren't always around to witness it or calm people down. We need more support staff at night [Name of another person who uses the service] bangs on doors at night and it wakes me up."
This was a breach of Regulation 12 (2) (a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the support staff about the people who they knew had risk identified. Support staff were able to explain what risks had been recognised in people's risk assessments and how to keep them safe.

Support staff told us they believed there were sufficient support staff on duty. However we found the staffing numbers were not sufficient to ensure people using the service had adequate support. Some support staff time, was devoted to cooking and cleaning tasks as opposed to being with people in a more therapeutic way. Support staff were engaged in tasks where people largely declined to assist. This meant that, there was little opportunity for them to engage with people to learn independence skills, in a way that would promote individual learning in a safe way.

One person told us "I wanted to have a bath last night, they refused to let me have one because there wasn't enough support staff" When we raised this with the acting manager they said the person was told "You can have a bath whenever you want but it has to be during the day shift, 8-8, when there's enough support staff." This indicated that there were not always enough support staff for the service to respond to people's needs whilst ensuring other people were safe in the home.
We spoke with eight people using the service, though some were unable to provide an opinion on what they felt about the service. One person told us that they felt safe living in the service. They told us, "I feel safe here, No one will steal anything here, they're all trusted."

We spoke with people's relatives and one person said, "[Name] is much happier now, there was a time when he was so anxious," and added, "The quality of care has improved." Another relative told us, "I think [name] is safe in the home, they would tell us if not. They added, "There have been a lot of ups and downs, but things are better now."

We looked at the staffing rota which detailed the numbers of staff on each shift. The acting manager stated this could be changed to compensate for changes. For example if a person's presented with behaviour that challenged. Staff told us that the staffing rota had been amended at the time the new people moved into the home. This had resulted in a reduction of care staff as the acting manager was working with staff on the floor, and considered to be counted in the staffing numbers. That meant on some occasions there were only three staff to care for the people in the home. Overall we found there were not sufficient, suitably qualified, skilled and experienced staff working in the home to ensure everyone's safety.
People were relaxed with the support staff group and at ease in asking for support and we observed people interacted well with support staff members. There was no hesitation by them to approach support staff

members when available to ask for assistance. This showed there was a good trusting relationship between the people using the service and support staff group.
Support staff were aware of the safeguarding and whistleblowing policies and those spoken with said that they felt they could raise concerns with the acting manager or a company director when they saw them. There was whistleblowing information available in the office and in a support staff in a communal area. That included the companies own whistleblowing telephone number as well as external contact details of the local authority and CQC.
Support staff were confident that people were safe from harm and said they would immediately report any concerns of abuse to a senior person at the service. They knew how to contact external agencies such as the local authority safeguarding or Care Quality Commission and said they would do so if their concerns remained unresolved. The provider had policies and procedures to embed the training support staff received on safeguarding and whistleblowing. There were also posters around the home with whistleblowing contact numbers for people to contact. Records showed that support staff had completed some training on how to keep people safe and staff spoken with confirmed they had been provided with relevant guidance.
We observed that safety latches had been installed to windows that prevented them from being opened too far. This reduced the risk that people would accidentally injure themselves. Personal emergency evacuation plans (PEEP's) needed to supply essential advice to support staff in the event of a fire were not completed for all people who used the service. This meant that if there was an emergency evacuation, support staff did not have information essential for a total evacuation which could increase the risk of harm.
Support staff were aware of the business continuity plan, produced by the provider which was available in the office. This provided information for support staff in the event of a significant failure of part of the building, water gas or electrical services, and included contact telephone numbers to use if an emergency occurred. That meant support staff could deal with emergency situations without delay. We asked support staff about the plan, of which they were aware, but had not needed to use yet.
The provider operated an effective recruitment procedures that ensured all required pre-employment checks were carried out before new recruits joined the service. This ensured as far as possible that only people who were suitable to work in the service were employed.

People we spoke with said support staff supported them with their medicines. One person told us, "I do get my tablets regularly." We saw there were reliable arrangements for ordering, storing, administering and disposing of medicines. There was a sufficient supply of medicines and they were stored securely. The support staff who administered medicines had received training and we saw them correctly following written guidance to make sure that people were given the right medicines at the right times. Records showed that in the 12 months preceding our inspection there had not been any occasions when a medicine had been incorrectly dispensed.
Support staff who administered medicines were observed regularly by one of the management team to ensure that they were competent and administered, stored and recorded the medicines in a safe manner.

Requires Improvement

Is the service effective?

Our findings

The acting manager and support staff knew about, and had been trained about the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We saw examples where support staff had assisted people to make their own decisions. This included people being helped to understand why they needed to be accompanied by support staff when they went out into the community so that they could safely manage hazards such as road traffic.

However, we found that MCA and the Deprivation of Liberty Safeguards (DoLS) were not always being implemented appropriately. For example there were concerns about people's human rights being deprived due to their lack of capacity. There were a number of people, who had long term mental health associated conditions and the majority of them had a formal diagnosis of mental health associated problems. There was evidence to suggest that there had been applications made in relation to DoLS, however there was no evidence to suggest that the majority of the people had been assessed in relation to having capacity. This meant people may have not been receiving the appropriate care and treatment due to the absence of capacity assessments.

When people lack the capacity to give their informed consent, the law requires registered persons to ensure that important decisions are taken in their best interests. A part of this process involves consulting closely with relatives and with health and social care professionals who know a person and have an interest in their wellbeing. From the discussions we held with people, we could not be sure they had the capacity to make informed judgements about their care and welfare. There had been no formal assessment done, so support staff were not able to assess if people were required to have a best interests decision completed to ensure the effective delivery and consent for care to be undertaken. Records did not demonstrate that support staff had supported people to make important decisions and ensure their best interests. That meant we could not be assured that people made informed judgements about their care and welfare.

We found that the registered manager had ensured that one person was protected by the DoLS. Records showed that they had applied for the necessary authorisation from the relevant local authority. This was because the person lacked mental capacity and required support staff to assist them in the community to keep them safe.

When we spoke with support staff they were able to recall essential protocols that should be adhered to when looking at implementing and meeting the needs of the people in relation to MCA and DoLS. Support staff told us that they were given training and felt they would be able to recognise if a person was subject to having a DoLS application processed. Records we viewed confirmed that support staff had undertaken this training.

In two people's care plans we saw that the care plan consent form was incomplete and had not been signed by the person who used the service. There was no explanation by a member of staff to indicate the reasons for them declining to sign. We spoke with one of the people who had not signed their consent form who told

us, "Before moving in they didn't ask what support I wanted." In another person's care plan it stated '[name] needs support in making complex decisions' and that 'support staff to apply the best practice of MCA when supporting [name]'. However no further information was included on what decisions the person was able to make or how the support staff could support them. We did not see evidence of mental capacity assessments and best interest's decisions being completed or reviewed for this person. That meant support staff were not provided with information to support people's decision making ability to ensure their human rights were recognised.

We saw support staff had received induction training and then on-going training in relevant subjects including how to support people who have mental health needs. The on-going training consisted of a work book on 'mental health awareness' and provided support staff with the meaning of terms associated with mental health. However this did not give adequate information to the scope of the needs of people who currently used this service, which meant staff may not have the skills to recognise, record and report on conditions that may affect people's long term health and safety. For example there was no information about self-harm prevention. Support staff told us they had a limited knowledge of issues such as self-harm but that senior managers were available on call for advice if needed.

Support staff received regular opportunities to meet with the acting manager to discuss their work and to plan personal and professional development. Brief training refreshers were completed in these meetings which had included, "dignity in care, whistleblowing and safeguarding people." Support staff confirmed that they had undertaken the training refreshers since the acting manager had commenced in post. However those staff spoken with were unable to demonstrate to us that they had taken all this training on board and improved their practices.

People who used the service were generally very complimentary about the food and told us they were able to have a hot breakfast if they wanted one. People were offered hot drinks and they were able to request hot drinks anytime when requiring them. People also had the benefit of a small kitchen area to make their own and visitor's drinks. This was stocked with a variety of hot and cold drinks and fresh fruit. We saw people used the kitchen and took fresh fruit throughout the day.

One person told us "If I want something to eat at night the night support staff will go out of their way to make me something to eat." One person told us that, "There's always loads to eat and drink here" and "If you don't like what's for dinner they make you sandwiches, the food is very good and there is always fruit on the table and milk in the fridge." We saw people helped themselves to the fruit bowl in the dining room. At lunch time we saw that people were offered a choice of meals and alternatives were offered for people who did not like the choices. Support staff told us they tried to provide choices and different options that people liked.

One person told us that they did not like how busy the dining room was at meal times and described it as being "like a train station" with people walking in and out. They went on to say that meal times were not very sociable, "Residents aren't very sociable, staff don't sit down to chat with you." We observed that although support staff were available in the dining area the nature of the comments were mainly task focussed "What would you like to eat?" "Are you finished? Do you want some pudding?" and although some members of support staff did eat a meal in the dining room, this was done at a separate table and did not encourage conversation with people who lived at the service. We spoke with the senior support worker about this. They told us there was no formal policy to direct support staff sit and eat a meal with people or not. Support staff told us they ensured that all the people were served first, it was then up to them if they had a meal and sat in the dining room.

We looked at how people with specific dietary needs, which potentially placed them at risk, were monitored. In one person's care plan it was recorded that the person had diabetes which was controlled by their diet and medication. The care plan stated, "If [Name] appears unwell or is showing signs of poor diabetic management, staff are to report to GP." No further details were included about what signs could indicate poor management of the diabetes which could lead to symptoms being missed by support staff and this would increase the risk to the person's health. A Malnutrition Universal Screening Tool (MUST) had not been

completed for this person. Clinical guidance (NICE quality standard QS24 Nutrition support in Adults) states that a malnutrition screen tool should be completed for people who live in care home, on admission or where there is clinical concern. For example there was no recording of meals for one person, where it stated in their care plan that a poor appetite was an indicator for their declining mental health. This meant the monitoring of people's health was not fully compliant with current guidance or care plan details.
We looked at the diet people were offered to ensure that they were eating and drinking enough to stay well. One person had been prescribed additional food supplements by their GP, and another required a special diet to ensure they remained healthy. However neither person had a MUST tool completed.
We noted that support staff were not routinely recording the meals that people were offered each day or monitoring what people had eaten. The absence of records reduced the ability of support staff to ensure that those more vulnerable people were following a reasonably varied and balanced diet. For example; one person did not want a pasta dish because it had courgettes in it. The member of support staff offered to remove the courgettes. When this was declined the person was offered a variety of other foods before they decided that they were not very hungry, and stated, "I just want some pudding." We spoke with the acting manager who said that a record would be commenced to record the meals each person had chosen. This would help to ensure people received the assistance they needed to maintain their health.
Records confirmed that people had been supported to see their consultant, doctor, dentist and optician. Two visiting health professionals spoken with were complimentary of the support staff and the assistance they provided.

Requires Improvement

Is the service caring?

Our findings

People who lived at the service told us that they thought the support staff were caring. One person told us, "When I moved in there was fruit and sweets in my room to welcome me, I thought that was nice." Another person told us that one member of support staff had, "Fixed my telly and put in a new light bulb." Another person told us, "Support staff are nice to me here and help me, if I need anything." and added, "People give me a choice."

However, we found dignity and privacy was not always upheld in this service. One person told us "Support staff don't respect your privacy." People told us that support staff had keys to their bedrooms and would often let themselves in without knocking. One person explained that this had occurred when they were only partially dressed which led to them feeling distressed and embarrassed. Whilst we were at the home we did not witness support staff knocking on doors before entering rooms. We did however witness a member of support staff stick their tongue out at a person. Whilst this was done in a jovial manner it caused the person to feel upset and they went on to say, "I don't like her doing that, it's a bit childish and I think it's rude." This showed that support staff did not always behave in a manner that respected people's dignity.
We spoke with the acting manager about these examples and she said she would speak to all the support staff about ensuring people's privacy and dignity through individual meetings. She added a number of support staff had also recently undertaken further training in this subject, which was discussed at individual supervision sessions, it is of concern that this training had little impact on support staff behaviour.

Support staff were observed to interact well with people. We saw support staff approached and supported a person when they became agitated. Later we asked the support staff member how they dealt with situations that caused people stress. The support staff member replied, "I try and find out why the person is getting agitated and try and provide reassurance." That demonstrated a proactive caring attitude. We looked at the person's care plan and the intervention undertaken by the support staff was supported in there. That meant support staff were following the care plan for the person, and had been developed over the time the person had been living at the home.

People could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wanted to do so. When necessary, support staff had assisted people to keep in touch with relatives by sending birthday and Christmas cards. People said that support staff helped them to make and receive telephone calls. One of them said, "I can talk to my family on the telephone as the support staff help me ring the number."

One person told us that the support staff helped them to purchase a bus pass which they use regularly to travel around the city. They explained that "I'm quite independent, they don't stop me going out but they like us to be back by 10-11pm for our own safety." This person looked on their independence positively, and this had been risk assessed by support staff giving them a framework to work to if the person did not arrive back by their agreed time.
Another person told us, "I can go out whenever I want." The person then went on to show a 'Keep Safe' card that they were given to carry with them which included details for an emergency contact and any difficulties

the person may have whilst in the community. It was clear the person had the capacity to make this decision and welcomed the freedom.

We noted the contact details of an independent advocacy service were displayed on the notice board in the home. The acting manager stated she would move this to a more prominent place to ensure the people living in the home could access the information more easily.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were able to choose how they spent their time at the home. One person told us, "I could stay in bed all day if I wanted (if they felt unwell)" and another stated that "I like drawing and making cards. We made Easter and Christmas cards." Another person told us that they enjoyed travelling and had visited Birmingham for a day trip. We saw people spent time in a variety of ways. Some people went out alone, others spent time alone in their room or watched television. People knew about the activities that were scheduled and some of them looked forward to them. One person said to us, "We are doing karaoke later, I like that." At the time of our visit we saw support staff attempted to engage others with this activity, but they did not wish to join in.

Support staff had consulted with people about the care they wanted to receive and had recorded the results in individual care plans. Support staff asked for people's personal choices and acted on suggestions made. One person told us that they were involved in completing their care plan every month. They told us that they asked for help dying their hair. The person told us that support staff helped them every fortnight to re-dye the hair and they told us that they had recently had it cut. Support staff and people who lived at the service told us that a meeting for people who used the service was held every week. One person told us that they used the meeting, "To ask for jacket potatoes for tea" and added they were supplied, "Really quickly."

We spoke with people's relatives and one relative said, "I know the support staff take [name] out to the car boot sales and sometimes goes out on his own round the shops in Queens Road, I know that's something he enjoys." Another said, "[Name] really enjoys the food, they tell us every time we speak."

The activity programme suggested by support staff was meant to improve people's life style and provide meaningful activities, though little of this was taken up by the people in the home. This meant that though the support staff suggested alternative pastimes, these were not planned to satisfy the needs of individuals and the uptake was restricted.

People told us that information was not always provided to them in a way that they could understand. In one person's care plan it was documented that they could not read but information was provided to them in a written format. One example of this was an activity timetable for the week, I asked they person what it was and they told us "I don't know what this is, I can't read." We asked if this information had been given to them in any other format, they told us that it hadn't been.

We spoke with a member of support staff who told us that, "I always talk through information with them" but stated that the home did not have any information available in an easy read format. Easy read is a way of presenting written information using pictures and simple sentences in a large font. This did not demonstrate a service responsive to people's individual communication needs.

Most of the support staff had worked at the service for several years which had enabled them to build close therapeutic relationships with people that lived within the home environment. When we spoke with support staff they told us how people wanted to be supported. We observed staff had supported some people to enjoy the interests they said they liked and to access hobbies and activities within the home. During our inspection visit we observed support staff sat with people and prompted them to express how they were feeling.

We saw from the minutes of the weekly meeting, where people were asked about the food choices for the following week and what activities they would like to undertake. We saw that some food suggestions had

been adopted. However we saw that some of the suggestions made by support staff, for example, swimming at a local swimming pool, had been turned down by all those attending the meeting. A weekly activity planner was available which included activities such as karaoke, movie and popcorn, a visit to a museum and arts and crafts. People told us the movie and popcorn were very popular. We asked a member of support staff who agreed, and said, "Movies and popcorn are used a lot of the time as they meet a number of people's needs." The activities programme was designed to meet the needs of the majority, but did not achieve person centred activities, due to poor support staffing ratios. We did see some examples of how support staff supported people to make choices, where the member of support staff offered the person several options for their lunch time meal before the person made their desired choice.

Support staff responded actively when people asked for assistance, for example one person asked, "Can I have some milk." The member of support staff promptly assisted the person. We observed other people responded to in a timely manner, including those requesting support. One person said, "They are good support staff here." Another person said, "I feel happy here and support staff are good to me." Though another person said to us, "I like to go swimming, but I haven't been recently." Support staff were limited by what time they could provide, and care plans that did not reflect person centred care and promote people's independence. One person's care plan explained that the person was at risk of falling when walking and 'would like support staff to accompany them into the community.' When we spoke with the person to find out if they received this support they told us, "If I ask support staff they tell me to go out on my own." We asked how this impacted on the person and they told us, "I don't go out on my own." This meant that this person's needs were not being responded to and did not demonstrate a service responsive to people's individual needs.
We saw one person was taken out in the home's transport for a doctor's appointment and resulted in another person living at the home having a raised stress level until the transport returned as they had fixated and unreasonable concerns regarding the vehicles safety. There was nothing in this person's care plan about how to deflect them from this type of behaviour and lessen their anxiety level. That meant this person's known anxieties were not responded to effectively to ensure they received adequate support.

People we spoke with at the home, stated they were mostly happy with the service, and were aware they could complain, but chose not to. Relatives we spoke with told us they had complained in the past, and would make use of the complaints procedure again if necessary.
We saw the provider had responded to formal complaints. Five complaints had been received in the last 12 months which had been investigated and the complainants had been responded to. Any learning had passed back to support staff as part of their development. For example there had been a complaint by a neighbouring resident in the street. The outcome was that a closer relationship between the home and neighbours had developed. That meant minor issues are dealt with more promptly and resolved, rather than them being left and getting out of hand.
The provider's complaints procedure set out the proper role of the local authority in undertaking complaints investigations if the person was not satisfied with the action taken by the provider.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place, but did not assess or monitor the quality of care effectively, to affect changes. A system to monitor that risk had been thoroughly assessed to protect people from harm and ensure their safety, was not in use. There was an audit system to assess and monitor the quality of the information contained in people's care records or to ensure information was current and up to date in order to meet people's needs. This was not effective as the care plan and risk assessment for a person who was at risk of taking their own life, was not well detailed and did not give support staff all the information required to ensure their safety.

We informed the provider's representative and acting manager about this in our feedback at the end of inspection day one. When we returned after a week the risk assessment had not been updated to include the information provided by the social work team. This placed the person at significant risk as it did not reflect information about previous attempts to take their life.
Individual personal evacuation plans (PEEPs) were not included in the business continuity plan and there were no evacuation details available for use in such an emergency. This was not revealed by the internal auditing process and could put people at risk, through a delayed evacuation of the building.
We asked the provider for the policies and procedures relating to people's safety. We were sent a number of policies about protection and reporting abuse. We were told that specific issues around people threatening to take their own life were included in these. These were not fully detailed and did not cover this issue, and had not been picked up by regular audit. That meant people were placed at risk from poorly detailed policies and procedures and poorly informed support staff.
This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Until 29 March 2016 there was a registered manager in post, and the provider has appointed an acting manager until the registration process could be commenced.
The culture of the home focused on group support instead of high quality person centred care. Support staff attitude and dress code was recognised as inappropriate at times, though these issues were not recognised or acted on by the acting manager. The support staff group did make efforts to include people in the running of the service but this was restricted by support staffing numbers to give people one to one support. The support staff group focussed on undertaking tasks for, instead of including people in a programme of education for independence and self-sufficiency. Care and support plans did not guide support staff to promote people's individuality.
There had been changes to the quality checks put in place in response to recent incidents. Records showed that the acting manager had continued the quality checks that the previous manager had put in place. We saw that the checks included making sure that medicines were safely managed and support staff received all of the support they needed. Financial checks were also in place, and additional audits were undertaken by support staff from the head office. This ensured people were protected from financial abuse.

People who lived at the service said that they were asked for their views about their home as part of everyday life. For example, people were invited to the weekly house meetings where they could speak with support staff about how well the service was meeting their needs. We looked at the minutes of the weekly

meeting where people were regularly prompted about what activities they wished to undertake. Support staff told us it was the same people who regularly attended the weekly meetings, but this was less than half of the people in the home. That meant that these people did not have an active voice in the changes and running of the home.

People who used the service were also included in an annual questionnaire, and the response from the latest circulated in 2015, was displayed on a notice board in the home. The same questionnaire was distributed to homes for elderly people as well as those with mental health needs and a learning disability. However it was not clear that people completing these had an understanding of what was being asked. For example, "Do we deliver care and support in a dignified manner, which respects individual needs, choices and preferences?"
We spoke with the acting manager who said she was unsure if anyone independent of the support staff group had assisted people in the home to respond. She added there were further questionnaires being sent out, which would include relatives and visiting professionals, and that advocates or someone independent of the support staff group would assist people in the home to complete their responses. The acting manager indicated all the responses would be considered to drive improvements in the home.

The acting manager and provider's representative stated the support staff had worked hard at forging good relationships with the local community. They have been invited to the street party to celebrate the Queen's birthday. They stated they would also be included in the next questionnaire to be distributed shortly.

We looked at the record of safety tests undertaken in the home. Most of these were done by the Prime Life's 'estates' team from the head office. The periodic test of gas appliances and electricity supply were up to date and were performed by appropriately qualified engineers. The fire alarm system was tested and re-set on a daily basis by support staff from the home, and is to ensure it is in good working order. There was a business continuity plan produced by the provider. This had information for support staff in the event of a significant failure of part of the building, water gas or electrical services. That meant support staff had information they could use to deal with a building emergency without undue delays.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Arrangements to assess and mitigate potential risk and provide safe care and treatment of people were not adequate. Staff did not have information available vital to the safety of people placed in their care. Arrangements to assess and mitigate environmental risks were not adequate. Staff did not have information vital to the safety of people placed in their care. This was a breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not effectively assess, monitor and improve the services provided. Systems had not been established to monitor and mitigate risks related to people's health and safety. These were breaches of Regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.