Aspire Healthcare Limited

Meadowbank Care Home

Inspection report

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20 January 2016

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

Summary of findings

Overall summary

The inspection took place on 19 and 20 January 2016 and was unannounced. This meant the registered provider or staff did not know about our inspection visit.

This was the first inspection of Meadowbank Care Home since the provider changed to Aspire Healthcare Limited.

Meadowbank Care Home is located in the village of Dipton near Stanley and is registered to provide accommodation and personal care for up to 14 people with learning disabilities. At the time of inspection there were eleven people using the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken action to propose to cancel the provider's registration, 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.

The service did not have a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a deputy manager in place since October 2015 and an acting manager who had been in post since November 2015. The area manager confirmed CQC would be notified when a suitable manager had been appointed at this location.

We found the fabric and condition of the premises to be in a state of disrepair; including two bathrooms that could no longer be used. All of the eleven people who lived at the home only had shared use of one ground floor shower room, which was not fitted with a bath. We saw that people's bedrooms were personalised, but all were in need of refurbishment and repair.

We found medicines practices were unsafe, particularly with regard to the administration of medicines.

We found a range of infection control hazards such as a corroded shower chair, damaged furniture in people's bedrooms and inadequate hand washing facilities. We found the home to be in need of refurbishment throughout.

We found there to be adequate numbers of staff to meet the needs of people who used the service when we inspected, with the deputy manager and manager also assisting with personal care.

People who used the service and their relatives told us they felt safe and that they had never had concerns about risks presented to people. We found Personalised Emergency Evacuation Plans (PEEPs) were in place, although these were not stored at hand in the event of an emergency.

Staff we spoke with were clear about their safeguarding responsibilities. However staff knowledge of whistleblowing procedures was inconsistent.

The provider had in place a range of mandatory training that helped equip staff to care for people who used the service. However refresher training was not well planned, with training information on the provider's training matrix not matching training certificates in staff files. Staff feedback regarding moving and handling training stated was that it was poor. We also found one instance of managers being unable to assure us or themselves about staff training credentials due to hard copies of training certificates not being in place.

People who used the service and relatives we spoke with were complimentary about staff knowledge of people who used the service. Keyworkers we spoke with displayed a good understanding of the personal histories of people they cared for.

People who lived at the home had little input in the planning of the homes menu and only limited choice of main meals. We found the dining experiences we observed to be functional and an opportunity missed by the provider to ensure people had a sociable time. People did not appear to enjoy their dining experience and these were not upheld as sociable occasions by staff either. The home did not effectively support people who needed assistance with diet controlled diabetes.

People we spoke with and their relatives were positive about the care provided by staff. However we saw staff concentrated on practical tasks at the home rather than person centred interactions.

The provider did not ensure activities were planned in line with their policy. Activities were not person-centred or co-ordinated. Some staff we spoke with had good awareness of people's likes, dislikes and life histories but did not engage with them in activities which reflected these.

Views of people who used the service had not always been sought or interpreted in ways which would help the service to improve.

Where complaints had been received, we saw they had been responded to and prompt actions taken.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The acting manager was knowledgeable on the subject of DoLS and had provided appropriate paperwork to the local authority to deprive people of their liberty, where it was in their best interests. Staff we spoke with were not always knowledgeable in the subject of the DoLS.

We found there were widespread and serious failings within the culture at Meadowbank Care Home, which encouraged task-led rather than person-centred care.

Procedures to review and check the performance of the home, and to identify risks, trends and areas for service improvement were not effective. Practices were not in line with policies and the expectations set out in the providers Service User Guide.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. We are taking enforcement action against the registered provider and will publish details when the process is complete.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service was in a state of disrepair with two out of three bathrooms were unable to be used.

The administration of medicines was not safe or in line with good practice as per the National Institute for Health and Clinical Excellence (NICE).

People were at risk because infection control measures were not in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The recording and planning of training was confused and could not be effectively accessed by on site managers.

Peoples' mealtime experiences were not good. Some people were at risk because of poor support to manage their diabetes needs.

Whilst appropriate Deprivation of Liberty Safeguard (DoLS) applications had been made to the local authority, some staff did not demonstrate an appropriate level of understanding of the Mental Capacity Act (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff did not attempt to make positive, meaningful relationships with people, whilst some staff were observed interacting poorly with people who used the service.

People who used the service were complimentary about staffing attitudes, as were relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were unable to take part in appropriate, meaningful activities. Their individual interests were not always explored and suggestions were not acted on.

People who used the service were not able to influence how the home was run and their voices were not heard, with suggestions not being acted upon.

Some staff had a good knowledge of people's life histories.

People's health needs were met through liaison with external healthcare professionals when their needs changed.

Is the service well-led?

Inadequate

The service was not well-led.

The home did not have a registered manager in post and neither the deputy manager nor acting manager had sufficient knowledge of the service.

Auditing of the service was ineffective, with systems not appropriately used to monitor, identify and improve poor practice.

The culture of the service was task-led care rather than being person-centred.

Meadowbank Care Home

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 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.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC.

We visited the service on 19 and 20 January 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service.

We spoke with five people who used the service. We spoke with nine members of staff: the acting manager, the deputy manager, the area manager, four care staff, the cook and the cleaner. After the inspection visit we spoke with three relatives of people who used the service and three external healthcare professionals. We also spoke with local authority professionals who commission with the service and the infection control team.

During the inspection visit we looked at five people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, information held on the home's computer systems, meeting minutes and maintenance records. We spent time observing people in the living rooms of the home.

Inadequate

Is the service safe?

Our findings

We observed one member of staff had begun administering medicines to a number of people at lunchtime without access to the Medication Administration Record (MAR) charts. When we asked them about this, they stated they could administer medicines from memory and would update the MAR charts later. This meant that safeguards were not in place to ensure medicines had been administered safely and in line with National Institute for Health and Social Care Excellence [NICE] guidance. We raised this with the area manager and acting manager and they took action immediately.

We found some inconsistencies within medicines records, for example three peoples records did not included allergy information. We also found that, whilst the service had in place body maps for the administration of topical medicines, body maps did not always clearly detail where about a person's body a topical medicine was required. This meant that people were at risk of having topical medicines applied incorrectly and unsafely.

We contacted the infection control team, who had carried out an inspection and provided a written report and action plan for the provider to reduce the risk of infections at the home. When we asked about actions taken as a result of the inspection neither the acting manager nor the deputy manager were able to locate the report. They agreed that the provider had not implemented the improvements required and people living and working at the home remained at risk.

During our inspection visit we observed risks of infection that had not been adequately assessed or mitigated. These included a shower chair which was being used by people living at the home which had considerable corrosion and could not be effectively cleaned. We also saw peoples' personal toiletries being kept in the shared bathroom which could promote cross infection.

We noted there was no hot water in a first floor staff toilet hand washbasin. We noted one first floor toilet hand washbasin for people who used the service had no running hot water either. The running water to washbasins in two adjacent bedrooms took over 60 seconds to reach a temperature that would have been adequate for, for example, shaving. We saw checks to ensure people were not at risk of being scalded by excessively high water temperatures had not been carried out since 4 November 2015. Had these checks been in place they would have identified that the hand-washing facilities in two upstairs rooms were not fit for purpose and presented a risk of infection. The Department of Health's Code of Practice for Health and Social Care on the prevention and control of infections and related guidance (2013) sets out the first criteria for providers to prevent against infection as, "Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them." The provider did not have such systems in place, which left people at risk of infection. The deputy manager told us they would arrange for someone to visit the service to ensure hot water was running again and to investigate the slow flow of hot water in people's bedrooms.

We also noted the radiator in the wet-room was extremely hot to the touch and there was no protector in

place to protect against the risk of people who used the service burning themselves. This presented a burns risk that had not been adequately mitigated. The Health and Safety Executive guidance document, 'Health and Safety in Care Homes' (2014) states the risk of burns from hot surfaces such as radiators can be mitigated by, "providing heat emitters with low surface temperatures; locating sources of heat out of reach, or; guarding the heated areas (eg providing radiator covers or covering exposed pipework)." We found none of these control measures to be in place.

The deputy manager told us that five people who used the service needed support to manage their diet controlled diabetes. However when we spoke with the cook they were unaware of who these people were and confirmed no specialised dietary options were in place to help support people with diabetes, for example, healthy options and low sugar desserts. This showed that the provider did not support peoples' dietary needs at the home and as a consequence, people living at the home were placed at risk. The National Institute for Health and Clinical Excellence (NICE) document, 'Type 2 diabetes in adults: management,' states that people with diabetes should be supported through management of their nutritional needs. For example, the guidance states providers should, "Provide dietary advice in a form sensitive to the person's needs, culture and beliefs, being sensitive to their willingness to change and the effects on their quality of life; Emphasise advice on healthy balanced eating that is applicable to the general population when providing advice to adults with type 2 diabetes; Encourage high fibre, low glycaemic index sources of carbohydrate in the diet, such as fruit, vegetables, wholegrains and pulses; include low fat dairy products and oily fish and control the intake of foods containing saturated and trans fatty acids; Integrate dietary advice with a personalised diabetes management plan, including other aspects of lifestyle modification, such as increasing physical activity and losing weight" (1.3.1 to 1.3.4). We found none of these measures were in place. This meant the provider had failed to do all that was reasonably practicable to mitigate risks presented to people who used the service.

We found other instances of people's specific healthcare needs being neglected. For example, one person presented with anxious behaviours throughout the inspection and, whilst the acting manager was able to demonstrate how to listen to the person as a means of soothing them, other staff did not interact appropriately or successfully with the person. We saw this person repeatedly being 'shushed' or ignored by staff rather than being cared for. We asked what specific measures were in place to reduce the risks this person presented to themselves and others. The deputy manager stated, "We ask them to leave the room if they don't calm down, so they know the behaviour is not acceptable." They and other staff members confirmed there were no other measures in place to mitigate or control the risk of emotional harm to the person. The conduct of staff was contrary to guidance issued by the National Institute of Health and Clinical Excellence ('Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges', 2015), which states providers should, "Aim to provide support and interventions," and, "Aim to prevent, reduce or stop the development of future episodes of behaviour that challenges; aim to improve quality of life." This demonstrated that the provider had failed to ensure the risks the person's behaviour presented to themselves and others was safely supported.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had not maintained the premises in a way that would promote the health safety and wellbeing of people living there and the staff who support them. All staff acknowledged the poor state of the building, with one describing the condition as, "Diabolical." We found that, of the three bathrooms in the service, two were out of commission and in a state of disrepair. The only bathing facilities in the service were a ground floor wet room with a shower and no bath. This meant that the eleven people using the service had to wait an unreasonable length of time to access washing facilities; and those who would prefer

a bath could not do so. We saw documentation in care files completed by the service's previous registered manager which confirmed that only one shower was available since at least March 2015. One person we spoke with confirmed they preferred a bath whilst another person's relative also stated they preferred a bath. This meant the poor state of the building had a negative impact on the people who used the service, removing their choice and limiting their personal hygiene preferences.

We saw evidence of water ingress through the ceiling in two bedrooms and in the first floor corridor. The deputy manager told us this was because the roof was leaking. These areas needed redecoration once the roof was fixed. The area manager confirmed to us in writing the day after the inspection that scaffolding was in place and repairs were underway.

We noted that the overall fabric and decor of the building was in poor condition and in need of refurbishment, particularly with regard to people's bedrooms. For example, in three bedrooms we saw drawers were damaged, whilst bare wood was exposed on vanity units. We found the kitchen to be in need of repair, with worn doors and handles held together with sticking tape.

We noted the last periodic electrical inspection was on 23 January 2009. These inspections must be carried out every five years to ensure that the electrical system at the premises are suitable and safe for people living and working at the home. The acting manager undertook to arrange an inspection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were stored in a fridge in the medicines room and fridge temperatures were consistently recorded as within safe limits. We reviewed the administration, storage and disposal of medicines. We found no errors in the Medication Administration Records [MARs] we sampled and found these charts contained an authorised signature list. A signature sheet helps anyone checking the use of medicines to see at a glance who has signed various parts of the MAR. We also saw each MAR contained a photograph of the person receiving the medicine, which reduced the likelihood of an administration error. We found there was no overuse of medicines intended to be used 'as and when' needed and clear recording of the administration of specialist medicines such as Warfarin. We saw people had been trained recently in the administration of medicines.

We reviewed four staff records and saw that the provider had carried out pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable people. We also saw that the registered manager had verified at least two references and ensured proof of identity was provided by each prospective employees' prior to employment. This meant that the service had reduced the risk of an unsuitable person being employed to work with vulnerable people.

People who used the service and their relatives expressed no concerns with their safety whilst at the service. One person told us, "Good, I am happy," and gave us a 'thumbs up' when we asked about whether they felt safe. Relatives told us, "I've never had any concerns because I know she's safe and happy," and "There is nothing to worry about." When we spoke with healthcare professionals they agreed they had not witnessed people being placed at significant risk of harm.

Staff we spoke with felt staffing levels were appropriate. One external professional raised concerns about staffing levels being adequate given the number of people who had mobility needs using the service. We found there to be adequate numbers of staff supporting people on the days of our inspection, and planned

in the staff rota. One relative told us they thought, "There are always plenty of staff," whilst another visiting healthcare professional stated when we asked them about the levels of staffing on their visits to the service, "There have never been issues on that front."

We saw some risk assessments in place to address risks people faced on a day to day basis, such as the risk of tripping or falling. These risk assessments were reviewed regularly. The service had not successfully adopted external risk assessment tools such as the Malnutrition Universal Screening Tool (MUST) and the Waterlow scoring system. MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw that the service had the relevant forms in place and had recorded people's weights but had not used the MUST scoring system to identify whether people were at risk of malnutrition and therefore required fortified diets. We did however see that the service regularly weighed people and sought Speech and Language Therapy (SALT) regarding people's dietary requirements. Of the five people's records we reviewed, we saw none had suffered weight losses recently that would have instigated fortified diets via the MUST tool. The Waterlow score is a means of estimating the risk of people developing a pressure sore. When we spoke with external healthcare professionals and asked them about the service's management of the risk of pressure sores, they stated, "We visit regularly to support with monitoring people's skin integrity. We've had no issues." They told us the service was proactive in alerting them to any concerns.

We spoke with four members of staff about their knowledge of safeguarding training and principles. Whilst all were clear on what constituted abuse and what they would do should they suspect abuse, not all staff were aware of whistleblowing procedures. Whistleblowing is the means by which someone working at a service can raise concerns about the service. This was an area in which the service needed to improve staff knowledge. When we looked at safeguarding policies we found the content to be detailed in terms of how safeguarding concerns should be treated, but the document was in need of review, having last been reviewed in March 2013.

All staff we spoke with acknowledged the shortcomings of the premises and consistently cited the provider as being aware of the need for refurbishment but failing to implement change. When we spoke with one external healthcare professional they supported this view, stating, "They have failed to buy equipment we've recommended on a number of occasions."

We found accidents and incidents were recorded and this information was shared with regional management, which meant people's individual accidents were not neglected and the provider had an opportunity to oversee relevant information

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans [PEEPS] were in place, meaning that people could be supported to exit the building by someone who would have access to their individual mobility and communication needs in the event of an emergency. These PEEPs were however held in people's care files and the acting manager agreed to review this with a view to making the PEEPs available at a suitable place, should emergency services require access to these plans.

We saw checks and servicing of equipment had taken place recently, including fire extinguishers, portable appliance testing (PAT), lift servicing and the gas boiler.

Requires Improvement

Is the service effective?

Our findings

The provider had in place a training matrix which was intended as a means of tracking staff training requirements and ensuring staff received refresher training where necessary. We found instances where this matrix was inaccurate, for example it contained no record of training courses we had found evidence of in staff files. Furthermore, the deputy manager and acting manager were unable to access staff training records on the provider's computer information system. The area manager attended the inspection in order that we could look at the matrix's record of staff training and acknowledged the service needed a system of tracking people's training that gave immediate line managers access to this information.

The majority of staff told us they felt sufficiently trained to carry out their roles, although one member of staff questioned the value of receiving moving and handling training via e-learning. One external professional also raised concerns about the levels of moving and handling training staff had received. We raised this with the acting manager who confirmed the area manager had recently undertaken moving and handling training and would be delivering face-to-face moving and handling training to all staff in the near future. We found minutes from a staff meeting of 14 August 2015 which confirmed moving and handling training would be delivered to all staff by an area manager. However this training had not taken place.

We reviewed five staff training records and found one person working at the home whose training record was not recorded in their staff file despite them having worked at the home for three weeks. Details of their training qualifications were also not on the provider's training matrix. This meant the deputy and acting managers did not know if this member of staff had suitable qualifications or skills to meet the needs of people at the home.

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

Staff we spoke with varied in their opinions of the levels of training they received and their experience of managerial support within the service. One staff member told us, "It's nice working here; it's all for the residents," another, "It's alright working here," whilst another said, "This is the worst company."

We saw that staff training courses in place, with staff undergoing safeguarding, first aid, diversity, manual handling, mental capacity, food safety, fire safety and infection control training. We saw that, as part of the induction process, staff had signed to confirm they understood a range of core policies.

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.

We found the acting manager demonstrated an understanding of consent and mental capacity

considerations. We found the provider had followed the requirements in the DoLS. When we spoke with individual members of staff we found however two staff we spoke with were not knowledgeable regarding mental capacity considerations and would benefit from refresher training.

We found evidence of peoples' annual reviews taking place in liaison with specialist learning disability services, as well as specialist physical health reviews. We saw people were supported to attend clinical appointments such as oncology, a diabetes clinic, opticians, dentists and gynaecology. We saw district nurses visited regularly, for example to take people's blood pressure measurements. We found however that these visits were not recorded in a manner that gave staff accessible knowledge of people's condition. When we asked the Deputy Manager about the apparent lack of systematic or organised communications with district nurse teams or primary care services they stated, "I have no idea when the district nurses are due to call and which residents they are coming to see". This demonstrated there was a poor understanding of how and when external healthcare was required to support people's needs.

When we spoke with keyworkers they displayed an understanding of people's likes, dislikes and personal histories. Likewise, where people had particular communication needs, staff were able to explain how they helped people explain their wants and needs.

People who used the service and the relatives were generally complimentary about the levels of knowledge and experience of staff. One relative told us, "Staff seem to know what they're doing," and another, "They monitor things and make sure she's well."

We saw that staff supervisions were undertaken regularly along with an annual appraisal. We also saw staff meetings had taken place recently as another means of sharing feedback. Staff we spoke with were generally positive about the opportunities they had to raise concerns and seek support.

People who used the service expressed satisfaction with the meals they received. We saw people who required a soft or pureed diet due to being at risk of choking had meals prepared in line with Speech and Language Therapy (SALT) guidance. We saw that there was a four weekly menu system in place and people were also had snacks and drinks available during the day. We saw there was a choice of menu options but this was limited. For example one evening meal presented a choice between fish fingers, chips and peas or fishcake, chips and peas.

The dining experiences we observed during our inspection visit were calm and unrushed with people who required help supported by adequate numbers of staff. We noted that staff ate at the same dining table after people who used the service, as a separate group (although in the same room), and there was an opportunity missed to ensure mealtimes were a sociable occasion. Similarly, we observed snacks such as biscuits were offered 'hand to hand', rather than, for example, a range of biscuits being offered on a plate with the person who used the service able to choose their preference. We noted some of the crockery used was chipped and we observed no fresh fruit on offer during the inspection. This meant, whilst people received adequate nutrition, staff did not make efforts to ensure mealtimes were pleasurable or sociable.

We observed that the environment of the home had not been adapted to meet people's needs. For example, doors to people's rooms had only small numbers attached to them with no other identifying or personalised information, whilst there was a lack of adequate signage on bathroom and toilet doors.

Requires Improvement

Is the service caring?

Our findings

During our inspection we observed interactions between staff and people who used the service to gather further evidence of how caring staff were. When we observed staff supporting people on a one-to-one basis we found them to be generally supportive and respectful in their interactions.

However we also found areas of poor practice. For example, one staff member told us the service, "Has a lot of feeders." They were describing that some people who used the service required support to eat a pureed diet. We highlighted this 'labelling' of people who used the service with the acting manager and area manager as undignified and disrespectful to people who used the service.

We spoke with one member of staff who was extremely passionate about the care they provided and who had an extensive knowledge of all people who used the service we asked them about. We also saw evidence they supported one person who used the service to walk to the local shops and back outside of their working hours. One relative gave us an example of how staff helped improve and maintain the independence of their relative, stating, "They go to the local shops with them – they never did that at home and it makes a difference."

We observed some staff being polite and respectful when they spoke with people who used the service. We noted however there was a lack of rapport between other staff and people at the home. We observed one member of staff sitting in the living room and, rather than interacting with people who used the service in a positive manner, fidgeted with keys for a number of minutes until they were required to perform another practical duty. This focus on tasks rather than people was a feature of the service during our inspection, meaning that, whilst people had their personal care needs and immediate wants met, staff did not always behave in ways that would help people feel valued as individuals, nor form trusting, meaningful relationships with them. The acting manager and area manager acknowledged this was a widespread and ongoing systemic problem in the service and an area the service needed to improve.

We arrived at the service on a morning and found all people who used the service to be well kempt and in clean and matching clothing. When we spoke with one relative they said, "They have a shower every other day and see the hairdresser once a week – that's important to them."

We saw people's rooms had been personalised with photographs and personal items although all bedrooms we saw were in need of refurbishment. When we asked people who used the service about their experience in the home they expressed contentment, with one giving us a 'thumbs-up' and another stating, "It's fine here."

We saw examples of people's end of life wishes being incorporated into their care plans, such as their choice of hymns that were important to them.

Relatives we spoke with confirmed there were no restrictions on the times they visited and that they considered the atmosphere in the service to be, "homely." Where people who used the service were able,

they told us they were content and looked after. Relatives we spoke with told us, "Yes, she's looked after well," "The service is excellent," and, "Staff are so caring." One external healthcare professional told us, "They provide good care there." Another however told us, "I'm always a bit shocked." They went on to described a time when they felt they were made to feel unwelcome by a senior member of staff.

As per their understanding of mental capacity considerations, the acting manager displayed an understanding of the need to support people via advocacy where they lacked capacity to make specific decisions. At the time of inspection nobody using the service had an advocate in place. The acting manager committed to contacting the local authority regarding advocacy arrangements for people who had recently had DoLS applications approved.

Requires Improvement

Is the service responsive?

Our findings

We found the service's provision of activities to be lacking, both in terms of planned group activities and in terms of responding to people's individual preferences. Each person who used the service had in place an 'Activities Outcome Plan' but this document detailed what the person had done that day, rather than planning any activities or hobbies they may be interested in. This was contrary to the Activities policy, which stated that a clear list of planned weekly activities should be in each person's file. This meant people did not receive personalised care with regard to the things they valued and took an interest in.

For example, we saw one person's care file indicated they had a passion for completing jigsaws. We asked their keyworker when the last time they helped the person complete a jigsaw and they could not remember. When we asked how the person would access such an activity their keyworker told us, "They would just do it if they wanted to." We reviewed the last four weeks of this person's 'Activities Outcome Plan' and saw the entries consisted entirely of either, "Watching TV," "Listening to music," or "Chatting." We found these entries to be the same in each of the persons care files we reviewed. One relative told us, "[Person] loves getting their hair done," and that this happened regularly. We observed people having their nails painted if they wished, as well as choosing a film to watch on an afternoon. However we did not see evidence of a planned approach to involving people in choosing activities and ensuring person-centred options were delivered. The service did not employ an activities co-ordinator and no member of staff held specific responsibility for this aspect of care provision.

A number of people using the service attended day services and were supported by a befriending service: these services were provided by outside agencies.

The provider's Service User Guide stated that, people who used the service had the opportunity to recommend activities via Residents Meetings. We reviewed the minutes from the meeting in October 2015, where people stated they had enjoyed a singer who had visited the home and had asked for them to make a return visit. The acting manager confirmed that this had not been arranged.

The service did not have a consistent system in place to routinely involve people in decisions regarding their care and seeking ongoing feedback. Service user questionnaires had been given out to people who lived at the home but had not been used to inform any in-house activity choices. We saw there were incomplete 'Service User Questionnaires' in some bedrooms. On some the phrase "Unable to give answers" had been written at the top. We asked the deputy manager if the results of these surveys had been compiled and analysed. They stated they did not know. We asked if any other attempts, other than the residents meetings, had been made to seek people's views and to act on those views, particularly for people who were unable to write or verbally communicate. The deputy manager confirmed there were no such methods in place.

We did not see evidence of people's preferences being acted on, nor a range of communication methods being used to best gather the feedback of people who used the service. We asked the acting manager about the lack of person-centred activities provision and they acknowledged this was an area the service needed

to improve.

Each person had a care file containing a range of person-centred information and a photograph. These gave details of people's medical needs, likes, dislikes, behaviours and personal histories, These files were large lever arch files and did contain a range of relevant information, such as people's behaviours and favourite pastimes, which could help staff gain an understanding of people's needs.

We found other instances of people's specific healthcare needs not being supported through person-centred means. For example, one person presented with anxious behaviours throughout the inspection. We asked the deputy manager about what specific plans were in place to support the person's needs, for example and de-escalation or distractions strategies that might be in place. We reviewed this person's care plan and found there to be no specific de-escalation or distraction strategies in place to help soothe the person when they were anxious. We saw there was sufficient background information regarding the person's interests and history to have put in place such plans to support them more appropriately and effectively. Guidance issued by the National Institute of Health and Clinical Excellence ('Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges', 2015) states providers should, "Aim to provide support and interventions," and, "Aim to prevent, reduce or stop the development of future episodes of behaviour that challenges; aim to improve quality of life; offer support and interventions respectfully, and; ensure that the focus is on improving the person's support and increasing their skills rather than changing the person." We found the provider had not followed this guidance.

The acting manager acknowledged the care files used could be cumbersome and involved unnecessary duplication of some details, whilst other details had not been updated in light of changes. They showed us a care plan they had started re-writing as an example although they had not made significant progress with this as yet.

Care plans were therefore not always person-centred to ensure all staff had the relevant knowledge to support people's individual needs. The acting manager told us they intended to make further improvements.

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

One relative told us staff had supported their relative well to overcome an injury and to regain mobility. When we spoke with the healthcare professional, they corroborated this and stated of the staff, "They seemed to support them well." This opinion was not always consistent across external healthcare professionals we spoke with, with one raising concerns about the acting manager's knowledge of people who used the service.

We saw the service had a complaints policy in place and relatives we spoke with were satisfied they knew who to approach if they had any concerns. Where complaints were made we saw they were responded to by the provider and resolutions sought. For example, a neighbour had complained about the noise made by a faulty external door. We saw this had been repaired promptly.

When we asked relatives about how the service had managed the transition of people to the service, one said, "[Relative] was settled very quickly," whilst a healthcare professional told us they had no concerns regarding this.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection, the home did not have a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The previous registered manager had left the service in October 2015 and, since then a deputy manager was covering the managerial role, alongside an acting manager who provided managerial support to this service and one other service in the region. At the time of the inspection the area manager told us they were in the process of finding a permanent replacement for the manager's position. and, since the inspection, the provider stated they intended to have a registered manager in place.

Both the deputy manager and acting manager supported people with aspects of personal care needs when required. Both were experienced in social care and we observed the latter interacting positively with a number of people who used the service. One person told us, "She's a good lass, a great boss." Relatives we spoke with raised no concerns about the availability or accountability of the management of the service. When we spoke with health and social care professionals they consistently described a reluctance on the part of the provider to put in place necessary changes, such as refurbishments or purchasing new equipment. One healthcare professional raised concerns about the willingness to listen to their professional advice regarding the provision of equipment to support people's needs.

When we spoke with the deputy manager throughout the inspection they displayed only a limited knowledge of people who used the service, as well as a limited knowledge of aspects of how the service should run. For example, both the deputy manager and acting manager were unable to locate a recent infection control audit they had been sent and both were unable to assure us about the training undertaken by staff they managed. This meant people did not benefit from a management team that had a comprehensive oversight of the service. Nor, at the time of our inspection, were staff led by managers who were able to give confidence through their knowledge of people who used the service. The majority of the concerns regarding the service appeared widespread and in existence prior to the current management team being in place. Despite that, we found no evidence of recent improvements in the service in the months prior to the inspection.

Both the acting manager and area manager were candid about the failings of the service, were open to challenge and shared all documentation we asked for promptly. They and the provider had not however ensured people were cared for in a person-centred way or in a safe and homely environment where staff had a clear understanding of their roles individually and as part of a team. We observed the culture of the service to be one in need of significant improvement. External health and social care professionals also had concerns about the culture of the service, stating, for example, "We go into a lot of places and it's not one I like to go into."

The Service User Guide states people who used the service could expect, "Person-centred care that meets the total needs of the service user," in, "A safe, caring and supportive environment." We found this was not the case and a number of significant improvements were required in order that the service could provide the level of care it promised.

We saw care plans were audited regularly to look for errors regarding, for example, condition of the file and personal details. Similarly, managers undertook intermittent health and safety checks to identify things like cluttered corridors or obvious hazards. We found detailed auditing and quality assurance was not yet in place and a range of the concerns identified throughout the inspection regarding the service should have been identified earlier and addressed had appropriate managerial oversight been in place. For example, the 'Infection Control' audit consisted of a record of the number of various types of outbreaks people using the service had suffered (or not). Likewise, the accident/incident audit consisted of a total number of accidents being recorded but with no other qualifying information, such as the cause of a fall. This meant, whilst some relevant information was being recorded, it was not detailed so as to enable anyone analysing the service, internally or externally, to draw meaningful conclusions from the information. The acting manager told us the provider was in the process of employing a Quality Manager to oversee auditing and quality assurance work across all the provider's locations but this was not yet in place. The provider had in place a 'Quality Manual', which gave an overview of how regular auditing and seeking other feedback was a means of driving continuous improvement, but we found practices in place did not follow these procedures. This meant the service had not ensured it was able to identify patterns or trends that could present ongoing risks, or opportunities for ongoing improvement of the service.

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

The majority of staff we spoke with were positive about the attitude and accessibility of the acting manager. A number of staff raised concerns about the provider's willingness to make changes within the service, such as refurbishments. One member of staff also stated, "I've never seen the owner since he took over." One person who used the service was complimentary about the acting manager.

We asked about links with the local community and found there were few. Whilst people enjoyed walking to the local shop with members of staff, and an external befriending service was used by some people who used the service, there were no other links with the local community. This meant people, who were at risk of social isolation due to their mobility needs and a lack of family nearby, had not always been given the opportunity to actively engage in the wider community.