Care Quality Commission

# Autism Hampshire

# Armstrong House

## Inspection report

3 Bassett Avenue
Southampton
Hampshire
SO16 7DP
Tel: 02380 766167
Website: www.has.org.uk

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## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 22 and 25 September 2015 and was unannounced. The home provides accommodation and personal care for up to six younger people who have learning disabilities. There were three people living at Armstrong House when we visited.

The home did not have a registered manager. 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.

At the last inspection in June 2014, we identified breaches of Regulations relating to staffing and safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We made two compliance actions. The provider sent us an action plan stating they were now meeting the requirements of the regulations.

# Summary of findings

At this inspection we found the previous concerns had not been met and also identified additional breaches of regulations. Monitoring systems were not effective in identifying areas for improvement and as a result, people's safety and the service they received was compromised.

Emergency procedures were inadequate to ensure people's safety. Routine checks on the home's fire detection and management systems had not been completed. Not all staff were aware of what action they should take in the event of a fire placing them and people at risk.

There were insufficient staff employed with a high reliance on non-permanent care staff. Staff had not attended all necessary training and were not supported in their roles.

Staff did not follow legislation designed to protect people's legal rights. Although adults people were referred to and treated as children.

Care files and individual risk assessments were chaotic and did not reflect the care and support people needed. Action to meet health needs had not always been taken. People were not supported to eat a balance healthy diet. People were not receiving adequate mental and physical stimulation.

Systems to manage medicines were inadequate and did not ensure people received all prescribed medicines safely. There were no systems to ensure people could receive 'as required' medicines such as paracetamol for minor illnesses or pain.

The views of people and relatives were not actively sought and people were not involved in decisions about the service.

The provider was recruiting new permanent staff and the recruitment process was safe and ensured staff were suitable for their role.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to the provider and will report on this when it is completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

There was a breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate 

The service was not safe.

Risks to individuals or the environment were not managed effectively. Staff were not all aware of what action they should take in an emergency and routine checks of fire detection and emergency equipment had not taken place.

Medicines were not managed safely. Some prescribed treatments were not available and staff had not been monitoring the amount of medicine being self-administered by one person.

There were not enough skilled and experienced staff to meet people's needs with a high reliance on non-permanent care staff. The recruitment process was safe and ensured staff were suitable for their role.

**Is the service effective?**

Inadequate 

The service was not effective.

Staff were not suitably trained and had not received appropriate support.

Legislation designed to protect people's rights was not correctly applied where people lacked the capacity to make some decisions themselves.

People did not always receive the correct healthcare and health monitoring they required.

People received appropriate support to eat and drink but were not supported to eat a balanced healthy diet.

**Is the service caring?**

Requires improvement 

The service was not always caring.

The lack of continuity of care staff meant people were unable to form trusting relationships with them. Non-permanent staff did not know about people's individual communication needs or their preferences.

People's privacy was protected and confidential information was kept securely.

**Is the service responsive?**

Inadequate 

The service was not responsive.

Care records were chaotic and had not been updated to reflect people's current health and personal care needs.

Systems did not ensure people received individual care which met their needs. People did not receive enough mental and physical stimulation and were not supported to develop new skills.

# Summary of findings

People and visitors were able to make complaints which were investigated.

**Is the service well-led?**

Inadequate 

The service was not well led.

The provider's quality monitoring systems were not effective. Concerns we had identified in our previous inspection report had not been addressed.

The views of people and relatives were not actively sought and people were not involved in decisions about changes to the service.

# Armstrong House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 22 and 25 September 2015 and was unannounced. The inspection was conducted by one inspector and a specialist advisor in the care of people living with autism.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. As a result of the short timescale before the inspection, we did not request the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We met all three people living at Armstrong House. However, due to their needs relating to living with Autism we were unable to seek their views about the service. Following the inspection we spoke with four family members of the three people. We also spoke with the provider's deputy principle, four care staff, and maintenance staff.

We looked at care plans and associated records for three people, staff duty records, staff files, accidents and incidents, policies and procedures, quality assurance records and records relating to the running of the home. We observed care and support being delivered in communal areas.

Inadequate

# Is the service safe?

## Our findings

Relatives did not raise any concerns about the safety of their loved ones living at Armstrong House. However, we found that people's safety was compromised.

Medicines were not managed safely. We were told medicines were only administered by staff who had completed medicines administration training and an annual update. Staff told us they had received initial medicines management training but had not received update training. This was confirmed by training records which showed that the staff responsible for administering medicines had not all received training in line with the provider's policy. Records showed when medicines were received into the home and when they were taken out of the home, such as when people spent time at their family homes. However, these records had not been fully completed and therefore did not provide an accurate record of medicines received into the home or taken elsewhere. Care staff completed a daily audit of medicines, recording the amounts of medicines held for each person. We saw that staff were not considering the information they were recording or taking action when required. For example, one person should have received two tablets of their medicine twice a day. The daily audit was recording that five tablets were being used on most days but staff had not acted to address the apparent overdosing. Senior staff had not been reviewing the medicines audits and therefore had failed to identify the discrepancy.

One 'as required' prescribed topical cream, which staff had been checking every day to confirm a full unopened tube was available, was found to be out of date with a use by date in June 2015. Staff had not identified this on their daily checks. For another person who was prescribed a special toothpaste due to gum disease and topical cream for a skin condition did not have these available. Staff had continued to record not available. Staff stated a family member was responsible for providing prescribed medicines but had not requested these be made available. People could not receive 'as required' medicines when they required them. There were no risk assessments or care plans to detail the administration of 'as required' medicines such as paracetamol for pain relief or fevers. The person's identified medical needs were not being treated due to the failure to have all prescribed medicines available.

One person was supported to self-administer their own medicines. There was no risk assessment or care plan in place to support staff and ensure consistency and safe self-administration. Staff had not identified that the person was taking more medicine than they were prescribed according to the prescription label on the medicine packaging and medicine records. The failure to identify that the person was not self-administering correctly placed the person at risk due to their taking additional medicines. Staff were signing a record to confirm the person had taken their medicines. Staff stated they had not received guidance as to how they should monitor the self-administration. They stated they "just watched him".

Medicines were not stored securely. Secure storage was available however, we observed a person access a key safe, remove the key and then open medicines cupboard and remove their own medicine to take home with them, when no care staff were present. Other people's prescribed medicines were also stored in the cupboard and accessible to the person. Staff stated they had not realised the person knew the key code to the office where the medicines storage cupboard was located.

The failure to ensure medicines were managed safely and ensure people received all medicines as prescribed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unsure about safeguarding reporting procedures. We spoke with the two staff on duty. One had completed safeguarding training and the other, who had worked at the home for just over two weeks, had not. Both staff said they would have no hesitation in reporting abuse to senior staff or someone else in the organisation but neither were aware of who they could report safeguarding concerns to if senior staff or the provider failed to take appropriate action. Staff responses indicated that they felt their responsibilities ended with their reporting their concerns to senior staff and if no action was taken there was nothing else they should do. Information about safeguarding and how to contact the local social services safeguarding team was available on a notice board in the office.

The failure to ensure all staff are aware of what action they should take if they had a safeguarding concern was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service safe?

Risks were not managed safely. We viewed the care files for two people living at the home and parts of the risk assessments and care files for the third person. Individual risk assessments did not cover all the areas necessary and were not up to date. We found risk assessments dated 2012/13 with no review dates. Risk assessments and subsequent risk management plans were not reflective of the current needs of the people whose care files we viewed. For example, the risk of a person who was missing meals each day due to their altered sleep pattern and a person who refused to meet their personal hygiene needs and how this should be managed.

Risk assessments in relation to the home were also seen. These covered a wide range of areas but none had been reviewed as per the provider's own timescales for review some being several years out of date. Senior staff told us they were reviewing all environmental and general risk assessments as per Multi-Disciplinary Team (MDT) process however, staff were not able to give clear response as to when these would take place and we saw they had previously been postponed.

The failure to ensure assess the risks to the health and safety of people and to do all that is reasonably practicable to mitigate against such risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff were aware of the action they should take in the event of an emergency. One of the two care staff we asked was unaware of the action they should take in the event of the fire alarms sounding. They had not received fire awareness training and stated they would have to ask the other staff member what they should do. This would result in a delay in emergency procedures being initiated and could compromise staff and people's safety. A senior staff member told us all new staff should undertake a planned induction. This included understanding emergency procedures which should be covered on the first day of their induction which had not occurred. Essential weekly checks of the fire detection and emergency equipment had not been undertaken since 15 July 2015. These were subsequently completed during the inspection and identified that the automatic fire door closures were not working for the lounge and kitchen and that emergency lighting at the bottom of the stairs was also not working. The failure to ensure emergency equipment was working placed people and staff at risk.

Staff showed us the emergency grab bag they stated they should take in an emergency. This was located inside a locked office and in an emergency getting this would have placed staff and people at risk due to the delay in exiting the building. Information inside the bag was out of date and contained records for people no longer at the home. There was also a torch which did not have batteries fitted. In an emergency at night this would again have placed people and staff at risk as the designated emergency exit route was through an area which would be dark as not covered by street lighting.

The failure to ensure emergency procedures were in place to keep people safe was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was not clean and action had not been taken to ensure people were protected from infection control risks. We identified a strong aroma of urine when we entered the home. Senior staff told us that in August 2015 carpets had been deep cleaned by external contract cleaners. This had been done due to the unpleasant aroma however, this had not resolved the problem. No further action had been taken to address the issue. We were shown night staff cleaning schedules which were ticked to indicate that the cleaning had been completed however, the home did not look clean. On the second day of the inspection we were told staff had been directed to undertake additional cleaning. No infection control audits had been undertaken and there was no annual infection control statement as required by the code of practice for health and social care on the prevention and control of infections.

The failure to ensure all necessary action to comply with the Health and Social Care 2008: Code of practice for health and social care on the prevention and control of infections and related guidance was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most permanent staff had completed infection control training and were aware of the precautionary actions they should take should people show symptoms indicating they may have an infectious condition. Staff stated they had ample supplies of disposable gloves and aprons.

One relative raised concerns about the lack of consistency of staff. They said there were "so many different faces" and "different staff every time I go to Armstrong House". They

Inadequate

# Is the service safe?

felt the lack of continuity in management and staff was having a detrimental effect on the service provided. Other relatives also commented on the lack of continuity of care staff.

There were not enough staff employed to ensure people received care from a consistent, experienced staff team able to meet their needs. Staffing levels were determined by the level of care and support individual people required. This was recorded on the duty roster taking into account times when people would not be at the home. We were told there were always two staff in the home when anyone was at home. When we arrived at the start of the inspection one person was at home, the other two people were at college. There was one member of care staff and a new care staff member who was on observational shifts as part of their induction. We were told observational shifts were to enable new staff to familiarise themselves with the needs of people and how support should be provided. Senior staff told us staff on induction observational shifts were not included in staffing numbers. Therefore, although the duty roster stated there should be two care staff there was in effect one member of care staff in the home.

The duty roster showed that every day there were shifts that required to be covered by non-permanent staff. Duty rosters viewed showed that throughout August and September 2015 there had been frequent occasions when one permanent staff member had been on shift with a variety of non-permanent staff. We were told these were covered by permanent staff undertaking additional shifts, staff for the linked college doing additional hours in the home and the use of the provider's bank staff and external agency staff. At night the home had one awake staff and one asleep staff member. Duty rosters showed that frequently the awake staff member was not a permanent member of staff. Staff told us they did not always know the level of competency of non-permanent staff.

A relative told us how the lack of permanent staff affected their loved one. The person liked their belongings to be left in a particular place and if these were moved they would then destroy them. The relative told us how non permanent staff did not always understand this and moved items left in a communal area which they, the relatives, had then had to replace as they had been destroyed. Staff told us the lack of permanent staff impacted on the lifestyles of people and restricted external activities. Some people required two staff if they were accessing the local community. Care staff said this could not be two staff who did not know the person well such as bank or agency staff. Care staff said that throughout August and September 2015 people had not been able to go on outings and external activities as often as they would like to do or as planned within individual weekly schedules.

The failures to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that people's care and support needs are met was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed the process used to recruit staff was safe and helped ensure staff were suitable for their role. The provider carried out all necessary checks to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. New staff confirmed the recruitment process had been thorough and they had had to provide evidence of their identity. One care staff told us their start date had been delayed whilst they waited for their pre-employment checks to be completed.

Inadequate

# Is the service effective?

## Our findings

At our last inspection in June 2014 we found that people's rights were not always protected and staff were not following the principles of the Deprivation of Liberties Safeguards (DoLS). The provider sent us an action plan which stated they were addressing the concerns and would be compliant by the end of August 2014.

DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Staff said none of the three people living at Armstrong House were able to leave the home on their own and security measures were in place to prevent them leaving. We were shown DoLS applications for two people however, these had not been fully completed. Key information was missing such as the reason why the individual needed to be deprived of their liberty and information regarding the person's communication needs or other professionals involved with their care. There was no evidence that these had been submitted to the local authority. For one person no DoLS application was available. People's legal rights were therefore not safeguarded.

The failure to comply with the Deprivation of Liberties Safeguards was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's ability to make decisions had not been assessed and recorded appropriately, in a way that showed the principles of the Mental Capacity Act, 2005 (MCA) had been complied with. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Everyone living at the home was over eighteen years old and therefore legally could make their own decisions unless assessments of their mental capacity had been completed showing that, even with support, they could not make the specific decision in question themselves. Although care plans contained some mental capacity assessments and best interest decisions these did not cover all significant decisions which were being made for and on behalf of people. For example, decisions about 'as required' medicines such as for pain relief. Senior staff told us they would be ask family members for permission however, all people were over eighteen years old. Mental capacity assessments had not been completed to determine if the person could make this decision themselves or if a best interest decision should be undertaken. The assessments did not include information as to how the person had been supported to understand and make the decision or how they had been supported but remained unable to make the decision.

Care staff were unclear about their roles and responsibilities in respect of mental capacity and DoLS legislation. When asked specific questions care and senior staff stated they would ask permission or consent of people's parents. For example, when we asked about 'as required' medicines for minor illnesses. Within care files we saw consent forms completed by people's parents for a range of health, care and support activities. There was no supporting assessment to show that the person could not make some or all of these decisions themselves. Senior staff stated people would be able to make some of these decisions. The consents provided by parents were therefore not in line with legislation and people's rights to give or withhold consent were not guaranteed.

The failure to ensure that decisions about consent reflect current legislation and guidance and that staff followed these at all times was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in June 2014 we found the provider had failed to ensure that staff were receiving regular supervision. Supervisions provide an opportunity for managers to meet with staff, provide feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. The provider sent us an action plan which stated they were addressing the concerns and would be compliant by the end of July 2014.

A senior staff told us that staff should receive formal supervision every six to eight weeks. We found that whilst most staff had received a supervision session within the previous eight weeks two out of the eight permanent staff had not. There were no dates identified for the other staff to receive their first supervision session. We were told new staff would receive additional formal supervision sessions. Senior staff told us they would meet with new staff at the

# Is the service effective?

end of their first week. However, one new care staff member had not had any formal supervision although they were in their third week of employment. Not all permanent staff had received an appraisal.

Staff were not receiving all necessary training to ensure they had the necessary skills to care for people. We were told the provider's policy was for new staff to have a comprehensive induction and undertake the Care Certificate. This sets the standards people working in adult social care need to meet before they can safely work unsupervised. One new member of care staff who had been working at the home over two weeks told us they had not yet received their induction pack or information about the care certificate. They had not completed any training and the only training they were booked to do was fire awareness at the end of their third week. Duty rosters showed that from the week following the inspection the new care staff member would be rostered as a full staff member without having completed any additional training.

Records showed staff had not completed all essential training or updates where these were required. On the second day of the inspection we were provided with a document showing training which had been identified as required with some being booked for completion in the three months following the inspection. This identified significant gaps in the training staff had received. This including training to meet emergency health needs such as epilepsy, and first aid. It also included training to understand and meet the needs of people using the service such as autism awareness and intervention training to support people who may place themselves or others at risk. Where staff had completed training such as safeguarding, they were unable to demonstrate that the training had provided them with all the knowledge required to keep people safe. There was a high reliance on the use of non-permanent staff. Senior staff said that they were not always aware of the competency of these staff which impacted on people's care and lifestyles.

The failure to ensure that staff were supported and had undertaken all relevant training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff members told us they could access senior staff should the need arise and said that when necessary senior staff had worked shifts with them.

People's relatives did not identify any concerns with the way people's health needs were being met. However we found people's healthcare needs were not met. People did not have fully completed, up to date health action plans. Health action plans should contain information about people's past medical history, immunisations and health risks. These help plan for and ensure current and potential future health needs are monitored and action taken to meet these needs. We asked a permanent care staff member where health actions plans were held and were told "if there are health action plans they will be in those folders". The failure to have health action plans placed people at risk of not having all health needs identified and met. Hospital passports, which should have contained all relevant information for hospital staff had also not been completed with blank or partially completed forms seen within care plans. Should a person require hospital treatment, hospital staff would not have had easy access to all relevant information to meet the person's needs.

Within the care plans we found examples of when people had seen their GP but the action requested by the GP had not been followed. For example, on 2 April 2015 a person had seen their GP following weight loss of two stone. The GP was concerned and had requested blood tests to aid diagnosis and treatment plan. The first appointment for these, on 15 April 2015 was cancelled although records did not say why or who had cancelled the appointment. A second appointment was made for the 30 April 2015 (four weeks after the GP requested the tests) however, the person refused the blood test once they were at the clinic. There were no further references to the blood tests within the person's records. A care staff member said the GP had suggested a urine test but there was no record of this being obtained or why it was not obtained. There was no reference in the person's notes to the urine test. There was no subsequent records of discussion with the GP about the person's weight loss. Nor was there information about action taken in order to assist the person to understand and cooperate with the obtaining of medical specimens, such as desensitisation to blood tests. No action was taken to monitor the person for further weight loss. Another person's record showed a doctor had requested a scan for possible head injury. However, there was no subsequent information about this. The failure to ensure people receive all necessary health treatment has placed people at risk now and in the future.

Inadequate

# Is the service effective?

The failure to ensure that people received all necessary health care was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received appropriate support to eat and drink however they were not receiving a nutritious diet. Two relatives were concerned that diets may not be appropriate. Drinks were available throughout the day and people were able to request or help themselves to these. Where staff had identified that people were either losing weight or gaining weight there were inadequate nutritional risk assessment and care plans within their care files to monitor this by weighing or to ensure people were encouraged to eat a suitable diet for their individual needs.

The limited nutritional plans to encourage better food choices were incomplete. They did not contain any review dates or evidence of outcomes or success. Staff were not observed to be encouraging people to eat a healthy diet.

One person's weight had significantly increased during the recent years whilst living at Armstrong House. There was no record of this concern or investigation into how this could be better managed or the detrimental effect the weight gain would have on the person's health. We observed the person provided with a lunch meal which was not nutritionally balanced or appropriate for someone who had gained weight. The lunch meal consisted of high fat, low nutrition foods of chocolate biscuits, crisps and cheese on toast. The person did have a support plan written by specialist services however, there was no evidence that this was being followed.

Requires improvement

# Is the service caring?

## Our findings

None of the four relatives we spoke with raised any concern about privacy or dignity. However, one said that the lack of consistent staff meant their loved one was unable to establish a trusting relationship with staff.

Staff spoke fondly of the people they cared for. However, the reliance on non-permanent staff meant staff would not be able to form long term caring relationships with people. Although all people were over 18 years old they were treated as children instead of adults. Care and senior staff constantly referred to people as 'boys' or 'the boys'. Parents were considered to have the right to make decisions without consultation with people. Not treating people as adults was disrespectful. We raised this with the provider's senior staff who agreed there was a need to ensure people were viewed and treated as adults.

Staff did not always communicate effectively with people. When staff interacted with people the interactions were upbeat and positive, however these interactions were very limited and could not be called engaging interactions. We observed very few effective interactions between care staff and people. For example, we observed a staff member prepare and serve a person with their lunch. No verbal or other communication was observed during this time. At another time staff failed to consider how a planned fire alarm test may impact on a person. The person was sat in the lounge and was not warned of the pending fire alarm test. People living with autism are known to have heightened anxiety levels and often adverse reactions to sudden noises and changes in the environment. Staff should have anticipated that the alarm test could be distressing for the person and provided a range of support from ear defenders to encouraging the person to undertake an activity outside during the test. The person was not observed to be distressed however, the failure to consider the impact of the fire alarm test on the person or to support them during the test demonstrate a lack of caring by staff.

There was limited information in people's care files about their communication needs and due to the lack of engagement we were unable to observe that staff were able to effectively communicate with people. One person used an alternative communication system but staff had not received training in this. We interacted with one person using a combination of signing and alternative communication methods. The person engaged in modelling behaviours such as writing notes and flicking through paperwork which were opportunities for potential engagement by care staff. However, the care staff member supporting this person was seen in another room on their personal mobile phone instead of engaging in meaningful effective communication with the person. The person was interested in communicating but was not supported in this. The person appeared happy although they were exhibiting some sign of self-stimulatory behaviours and repetitive sounds and actions. This could Indicate that they were not appropriately stimulated. Senior staff were informed about our concerns and took action to ensure care staff did not use their personal mobile phones during work time.

There was limited evidence of people being involved in decisions about their lives and the care they received. Individual feedback forms from people were included in key worker paperwork; however those that were completed did not indicate how people's requests were being met. For example, one person identified they would like to try new foods including melon and grapes. There was nothing recorded subsequently to show that this had been facilitated or if they had enjoyed the new foods. Documentation in care files did not show that people were included in discussions and decisions about their health and welfare. People were also not consulted or included in decisions about the home.

Staff ensured people's privacy was protected by speaking quietly and ensuring doors were closed when providing personal care. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

Inadequate

# Is the service responsive?

## Our findings

We received mixed feedback from the four family members we spoke with. Some felt they were involved in discussions about care and how needs should be met whilst others felt this was not the case

People could not be guaranteed to receive care and support that was personalised and responsive to their individual needs. Care and support files were chaotic and did not provide clear information about what people's needs were or how they should be supported. The reliance on non-permanent staff exacerbated this situation as these staff did not know the people they were caring for or how to meet their individual needs. Each person had up to three care files. However, there was no pattern as to what information should be in each file or how these should be organised. One person's feedback and involvement in their own pathway was evidenced and staff were documenting their need for support from the providers Multi-Disciplinary Team (MDT) to assist the person. However, staff request for support did not appear to have been provided and the requests had not been followed up to ensure the support was available. This meant staff did not receive the correct guidance to support people with complex needs in the most appropriate way. Senior staff subsequently found some further information in files held in another service located on the same site as Armstrong House. Care staff would not have been able to access this information, which was in a locked office in the day college. Photographs were used which would be helpful and showed some personalising of information. The failure to ensure staff have the necessary support from specialists meant people would not receive support based on current best practice and procedures.

The service supported younger adults and we were told it was not intended to be a long term home for people once they had completed their courses at the linked college. However, at least one person was effectively living at the service long term and had been for several years. Their action plans from 2013 stated the person was commencing transition to more independent living. A review was held in 2014 and the decision was made that the person should remain at Armstrong House for a further year. However, there was no plan in place to increase the person's independence skills or how their transition would be managed.

People were not receiving enough mental and physical stimulation or activity. One person was supported to take part in daily physical exercise, however the other two people were not. Each person had a weekly plan detailing what they would do each day. For one person who did not attend the linked college their plan stated they should be going for a walk each day. Daily records of the care and support they had received showed that this was not occurring and they were spending the majority of their time in the home either in bed or watching television. During the inspection this is what we observed. Staff told us the person joined a weekly Sumba class with the linked college however that appeared to be the only activity they did each week. Relatives commented that they were concerned that people did not have sufficient activities and that there was reliance on the use of computer technology to occupy people. Relatives were concerned that this would lead to patterns of behaviours and routines which would become hard to change. One relative told us they had heard staff offering the choice of the iPad or the computer to a person. They had not been offered a physical activity or one that may have led to new skills being learnt such as baking or gardening. Relatives spoke about other activities such as swimming and gardening people had previously enjoyed but no longer seemed to do. Staff told us the reliance on non-permanent staff meant people were unable to go out regularly.

The failure to ensure that care is planned to meet people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us reviews were planned but they had not been consulted about other aspects of the service or their views sought. They were not, for example, involved in the recruitment of new staff or kept informed about changes to the management of the home. Relatives were unsure who was managing the service. On the second day of the inspection we were told new carpets and lounge furniture were to be provided. We asked if people had been consulted on the choice and were told by a senior staff member that people had not been involved in this decision. We were told one person had been involved in decisions about some furniture for their bedroom but this was the only example of people being involved in choices and decisions about the home.

Inadequate

# Is the service responsive?

We viewed the complaints record which showed that when complaints were made these were investigated comprehensively. An external consultant was completing an investigation into a complaint which had been received in May 2015. We saw that this had been comprehensive and acknowledged that the service had failed to provide the support a person required. The relative who had raised the complaint received a full written response including, an apology. An action plan had been produced as a result of the complaint.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led. Management systems had not ensured that the breaches of regulations we identified in June 2014 were acted on. The provider's quality monitoring systems had not identified that people were not receiving safe, effective, responsive care or led to improvements in the service provided.

One relative said they were not sure who the manager of the home was. They said they felt that standards "had slipped and gone downhill". Another commented that there had been a lot of changes in staff and the management and they were not kept informed about the changes or the reasons for these.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The acting manager, who had also been responsible for managing a nearby service, had been planning to apply to the commission to become the registered manager. However, we were told on the second day of the inspection that they were no longer working at the home. Three weeks before the inspection a senior staff member from another of the provider's services had commenced providing some management support. However, they were also responsible for managing their other service and were therefore unable to provide a high level of support to Armstrong House.

In July 2015 the provider undertook an investigation and an audit into a number of concerns which had been raised anonymously about Armstrong House. Their investigation had identified that many of the allegations were substantiated and they had produced an action plan stating they would have addressed these concerns by the end of August 2015. The action plan had not ensured that the necessary improvements had been made and that the provider had learnt from the investigation.

The provider did not have an effective system in place to monitor and improve the quality of the service provided. There was no auditing of care records or files, infection control, no auditing to ensure staff were receiving all necessary training or supervisions, and no auditing of the care people were receiving. Staff did not identify areas for improvement with senior staff. For example, staff were completing daily cleaning tasks which included wiping the inside of the microwave. They were signing to confirm cleaning tasks had been completed. However, they had failed to inform senior staff that the microwave required replacing as the inside was damaged and therefore should not be used. We found aerosol air freshener sprays and garden fence preservative stain in areas of the home accessible to people. These products were potentially dangerous and should have been kept secure. Staff were in these areas and had not noted or acted on the risk.

The failure to have suitable systems to monitor the quality of the service provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had identified that the quality monitoring systems in place were inadequate and had contracted with an external consultant to design and implement a new quality monitoring system for use in all their homes. This system was not yet fully developed or in place. The consultant was also rewriting the provider's policies and reviewing procedures for risk assessments.

There was inadequate forward planning to improve and develop the service or ensure a safe service was provided. For example, to ensure adequate numbers of staff with the necessary skills, knowledge and experience were employed. Duty rosters showed shifts were not covered until just before staff were needed. For example, there were no night staff rostered for the night of the first day of the inspection. This was covered at about 4pm. On the second day of the inspection staff were required for the next day. Senior staff told they were recruiting new staff with interviews occurring on the first day of the inspection. The management team had identified that recruiting more direct care staff was vital in improving and maintaining the service people received. However, despite the knowledge that they had insufficient permanent staff the provider had admitted two new people to the home in September 2015. As with the other people living at Armstrong House, both people had complex needs requiring individual, or on occasions two staff to support them in the house and outside of it.

Throughout the inspection the senior staff present were open, honest and transparent. Whilst they had not been aware of all the concerns we identified they were aware of

Inadequate

# Is the service well-led?

the need to improve the service. However, the senior team had only been in post for a few weeks and had other responsibilities for other locations and services belonging to the provider. Between the two days of the inspection action was initiated by senior staff and we were provided with an initial action plan. This demonstrated a willingness by the senior team to address the concerns. One care staff told us they "loved working at the home". They were unable to tell us what the values of the home were other than to suggest they were to look after the people living there.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The provider has failed to ensure people received individual care which met their needs and preferences. Regulation 9 (3)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>Systems and processes were not established and operated to ensure the Mental Capacity Act 2005 was followed. Regulation 11(3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems and processes were not established and operated effectively to prevent abuse of service users. Legislation to protect service users from being unlawfully deprived of their liberty had not been complied with.<br><br>Regulation 13 (2) (4)(b) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>People were not protected against the risks of receiving inadequate care and treatment. Risks to the health and safety of people had not been identified and action taken to mitigate against these risks. Medicines were not managed safely. The provider had failed to ensure the premises were safe. The code of practice for health and adult social care on the prevention and control of infections and related guidance has not been complied with.<br><br>Regulation 12 1, 2(a)(b)(d)(g)(h) |

**The enforcement action we took:**
We have issued a warning notice telling the provider they must be compliant by 16 December 2015

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider has failed to assess, monitor and improve the quality and safety of services provided. Records of the care provided to each service user were inadequate.<br><br>Regulation 17 1, 2(a)(b)(c)(e) |

**The enforcement action we took:**
We have issued a warning notice telling the provider they must be compliant by 16 December 2015

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. Staff had not received appropriate support and training to enable them to carry out the duties they are employed to perform. Regulation 18 |

This section is primarily information for the provider

# Enforcement actions

**The enforcement action we took:**
We have issued a warning notice telling the provider they must be compliant by 16 December 2015