Ark Specialist Healthcare LLP

Advent House

Inspection report

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Tel: 01924826868

Date of inspection visit:
21 July 2016

Date of publication:
16 November 2016

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

Summary of findings

Overall summary

We inspected Advent House on 21July 2016. This was an announced inspection. We informed the registered provider at short notice (48 hours before) that we would be visiting to inspect. We did this because the location is a small care home for people who can be out during the day and we needed to be sure that someone would be in. The service was last inspected in July 2014 and was meeting the regulations we inspected at the time.

Advent House is a two storey purpose built facility which is registered to provide 24 hour accommodation and nursing care for up to 10 people who have a learning disability. The service is accessible for people with a learning disability and who may need to use a wheelchair. The service is located within a quiet residential area with open views to fields. At the time of our visit there were six people who used the service (four permanently and two people for respite care).

The home had a registered manager in place. 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 registered provider had failed to ensure that suitably qualified staff were on duty at all times. Some people who used the service had been assessed as needing nursing care; however there wasn't always a nurse on duty. There had not been a nurse working night duty for two years and more recently some day shifts had not been covered. Insufficient numbers of nurses were employed to cover all shifts. The registered manager told us they would take immediate action and ensure the service was staffed with a nurse at all times.

Risks assessments for people who used the service were insufficiently detailed. This meant that staff did not have the written guidance they needed to help people to remain safe. Staff failed to recognise when incidents would be considered to be abuse and therefore needed referring to the local safeguarding team. This meant that processes were not in place to prevent people who used the service and staff from abuse. Incidents were recorded, however not analysed to reduce the risk of reoccurrence.

Checks of the building were carried out to ensure health and safety, however some water temperatures were low and below the recommended level for the prevention of legionella. There was no evidence to confirm that servicing had taken place on the fire alarm. This meant it may not work properly in the event of a fire, if regular checks are not carried out.

Staff did not understand the requirements of the Mental Capacity Act 2005 and associated codes of practice. Decision specific mental capacity assessments had not been completed and care records did not describe the efforts that had been made to establish that the least restrictive option for people. There were no records to confirm that 'best interest' discussions had taken place with family, external health and social

work professionals.

Staff were not trained to care and support people who used the service. Only 11% of care staff employed were qualified in first aid and only 60% of staff had received training around using physical interventions. This type of training needs to be refreshed on an annual basis, however for many staff this was over a year ago. The registered provider told us further sessions had been booked. From a review of the training matrix we found that only 70% of staff had received moving and handling training and only 37% of staff had received training around gastrostomy care. Staff had not consistently received supervisions and appraisals from 2014 to the date of the inspection.

Two of the three care plans we looked at were person centred and included detailed information on how the person needed to be care for. However, for one person the care records failed to provide sufficient information to enable staff to provide safe care and treatment. We found the lack of information around how to manage the behaviours that were challenge left the person and staff at risk of being injured. The registered provider sent us an updated behaviour management plan after our inspection.

People were supported to participate in leisure and social based activities; however activities for some people were limited.

We looked at the recruitment and selection processes and found that checks were undertaken before staff commenced work. The staff files included evidence that pre-employment checks had been made including written references, the completion of an application form and obtaining proof of identity. We observed that two staff had started work prior to the receipt of a satisfactory Disclosure and Barring Service clearance (DBS). The registered manager told us they would not routinely employ staff prior to the receipt of a DBS check; however a new person had been admitted to the service who required lots of support would have meant a shortfall in staff to support people. They told us that new staff had worked supervised until their DBS check had been returned.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered provider had systems for monitoring and assessing the service, however these were minimal and ineffective as they did not identify the concerns we identified at the inspection of the service.

People had access to healthcare professionals and services. In addition people had a hospital passport which contained information that would help hospital staff to ensure that care and treatment was provided in a way that the person would want it to be. In general safe systems were in place to make sure people received their medicines safely. However 'as required' guidelines were missing for some people who used the service. This meant staff did not always have clear instruction they needed to administer medicines. Staff encouraged and supported people at meal times. We saw that people were provided with a choice of food and drinks which helped to ensure that their nutritional needs were met. People had been weighed on a regular basis.

The registered provider had a system in place to manage complaints. Relatives told us the staff and registered manager were approachable.

There were positive interactions between people and staff. We saw that staff treated people with dignity and respect. Staff were attentive, respectful, patient and interacted well with people. Observation of the

staff showed that they knew the people very well and could anticipate their needs.

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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who used the service had been assessed as needing nursing care; however there wasn't always a nurse on duty. Insufficient numbers of nurses were employed to cover all shifts.

Risk assessments were insufficiently detailed to ensure the health safety and wellbeing of people and staff. Only basic plans of care were in place for managing risk.

In general safe systems were in place to make sure people received their medicines safely. However 'as required' guidelines were missing for some people who used the service. This meant staff did not always have clear instruction they needed to administer medicines.

Checks of the building were carried out to ensure health and safety, however some water temperatures were low and below the recommended level for the prevention of legionella.

Is the service effective?

Inadequate

The service was not effective.

Staff did not understand the requirements of the Mental Capacity Act 2005 and associated codes of practice.

Staff were not trained to care and support people who used the service. Staff had not always consistently received supervisions and appraisals.

People had access to healthcare professionals and services. Staff encouraged and supported people at meal times.

Is the service caring?

Requires Improvement

The service was not always caring.

The failings identified during the inspection posed a significant risk to people who used the service.

People and relatives told us that staff were kind and they were treated with compassion and their privacy and dignity was always respected. We saw staff responded in a caring way to people's needs and requests.

People had access to advocacy services. This enabled others who knew them well to speak up on their behalf.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was planned; however, some care records were insufficiently detailed to enable staff to provide safe care and treatment.

People were supported to participate in leisure and social based activities; however activities for some people were limited.

The registered provider had a system in place to manage complaints. Relatives told us the staff and registered manager were approachable.

Is the service well-led?

Inadequate

The service was not always well led.

Effective quality monitoring systems were not in place to ensure the service was run in the best interest of people who used the service.

Staff, people who used the service and relatives told us the registered manager was approachable and they felt supported.

Advent 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 checked 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.

We inspected Advent House on 21July 2016. This was an announced inspection. We informed the registered provider at short notice (48 hours before) that we would be visiting to inspect. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed all the information we held about the service. The registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI) during this inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We sat in communal areas and observed how staff interacted with people. We spent time with five people who used the service. Communication with some people was limited because of their learning disability. We spoke with one relative during the inspection and one relative after. We looked at communal areas of the home and some bedrooms.

During the visit we spoke with six staff, this included the registered manager, the nurse, three support workers and a visiting healthcare professional who was supporting a person who used the service during their stay. We also contacted commissioners of services to seek their views on the service.

We reviewed a range of records. This included three people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment, supervision and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the registered provider.

Inadequate

Is the service safe?

Our findings

During the inspection we looked at duty rotas and spoke with staff to determine that there was sufficient staff with the right skills and qualifications on duty at any one time. The registered manager told us that the amount of staff on duty depended on how many people were at the service. On the day of the inspection there were a total of six people who used the service (four who were staying at the home on a permanent basis and two for respite care). The registered manager told us there were usually five to six care staff and a nurse on duty to meet the needs of people who used the service. Following examination of duty rotas we identified that there wasn't always a nurse on duty. We asked the registered manager to see the contracts of people who used the service to determine if they had been assessed as needing personal or nursing care. From examination of records we were provided with we could not determine if people had been assessed as needing personal or nursing care.

We looked at duty rotas from 4 July 2016 to the 20 July 2016 and saw there were seven shifts (either an early or late) when a qualified nurse was not on duty. We found from discussion that there had not been a nurse on duty overnight for two years. The registered manager told us there were three to four care staff on duty overnight, however these were not senior staff. As we could not be sure of people's needs the registered manager agreed to staff the service with a nurse on duty at all times until we received clarification. After the inspection we contacted NHS Wakefield Clinical Commissioning Group who confirmed a registered nurse was required to be on duty at all times. Following the inspection we took action to ensure that a nurse was on duty at all times. In addition we raised safeguarding alerts to the local authority.

Insufficient numbers of nurses were employed to cover the service 24 hours a day. The service employed three nurses and one of whom was the registered manager. We were told that one nurse had recently left and the registered provider was actively recruiting to this post.

We also found that people who used the service were funded for one-to-one and two-to-one care but from the review of the rotas it was unclear how this was put in place. We did see that some people were receiving one-to-one care, as there were five to six staff on duty whilst we were at the home. However, it was not clear how the periods of two-to-one support were put in place.

One relative raised a concern with us that the person who used the service was assessed for nursing care but the last time they visited there wasn't a nurse on duty. They found that the care staff on duty although very kind did not understand how to meet the person's needs and were very concerned that they were not supervised by a nurse.

Another relative told us the person who used the service enjoyed going out and socialising, but that unless they came to the home to take the person out they did not go out often. They said, "We have repeatedly asked for an activity plan so that we can see what [name of person] is up to during the week but we don't get one so this has left us feeling we have to visit and take them out. It's not that taking [name of person] out is an issue but we are getting older and feel we fill the gaps in activity because the staff haven't the time to take them out." From examination of the rota we could not identify when additional staff were on duty to take

this person out. After the inspection we received information from the registered provider informing that the person did not respond well to having a planned approach to activities.

This was a breach of Regulation 12 (1) (Safe care and treatment) and 18(1) and (2) (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and operational manager failed to recognise when situations would be considered to be abuse and therefore needed referring to the local safeguarding team. Although staff had received safeguarding training they had not raised safeguarding alerts in respect of the lack of nursing staff. We pointed this out to the registered manager at the time of the inspection.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. Accidents were minimal, however, some of the people displayed challenging behaviour and this regularly led to incidents. Staff kept an individual record of any incidents, accidents or falls for each person who used the service. We asked the registered manager for an analysis of incidents, which we would expect to see as this would assist them to identify any patterns or trends. We found the registered manager was not completing an analysis. The only available records that provided an overview was the provider monthly visit record. The registered manager completed this document and we saw it asked for minimal information. We found the document did not assist the registered manager to determine any trends or patterns in relations to incidents.

Risks to people safety were assessed and some plans were put in place to minimise them but not all. The care file of one person identified risks when they were in the kitchen such as cuts when using kitchen appliances and scalds with hot water. This care plan also identified behaviours that challenged and clear action for staff to follow to ensure the safety and wellbeing of the person. The same person had a risk assessment for moving and handling and informed staff to use safe handling techniques but did not state what these were. The risk assessments did not detail what the actual risk to the person was when moving. The risk assessments in the second care file were insufficiently detailed. The person had been at the home for several months and presented with behaviour that were very challenging. They frequently assaulted people, were sexually disinhibited and destroyed property but the only documents in place were very basic support plans for daily living skills. We saw some mention of behaviours that challenge in these but they did not outline the extent of these or what action staff were to take when supporting the person.

This was a breach of Regulation 12 (1) (Safe care and treatment) and 13 (5), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Water temperatures of baths, showers and hand wash basins were taken and recorded on a regular basis to make sure they were within safe limits. We saw records that showed water temperatures were taken regularly. However, we did see that some water temperatures were low and below the recommended level for the prevention of legionella. We pointed out to the registered manager who said they would take immediate action to address this.

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

We looked at records to confirm that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire extinguishers and electrical installation. The certificate to confirm the servicing of the gas boiler was not available for inspection. This was sent to us after the inspection and confirmed that the

servicing took place on the day after the inspection. A certificate was not available to confirm servicing of the fire alarm system. We asked the registered manager to send us this after the inspection to date we have not received this document.

This was a breach of Regulation 15(1) (Premises and equipment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they felt safe. People told us they felt safe. One person said, "I like them [staff]."

An emergency evacuation plan was in place for people who used the service. This provided information about how to ensure an individual's safe evacuation from the premises in the event of an emergency. Records showed that regular checks were made by staff on the fire alarm to make sure it was in working order and that staff had taken part in fire drills.

We looked at the recruitment and selection processes in place at Advent House. We looked at the files for three of the most recent staff to be employed and found that checks were undertaken before staff commenced work. The staff files included evidence that pre-employment checks had been made including written references, the completion of an application form and obtaining proof of identity. We observed that two staff had started work prior to the receipt of a satisfactory Disclosure and Barring Service clearance (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with children and vulnerable adults. The registered manager told us they would not routinely employ staff prior to the receipt of a DBS check; however a new person had been admitted to the service who required lots of support would have meant a shortfall in staff to support people. They told us that new staff had worked supervised until their DBS check had come back.

At the time of our inspection people who used the service were unable to look after or administer their own medicines. Staff had taken responsibility for the storage and administration of medicines on people's behalf. We checked people's Medication Administration Records (MARs) and found these were fully completed, contained the required entries and were signed.

We checked records of medicines against the stocks held and found these balanced. The registered manager was able to describe the arrangements in place for the ordering and disposal of medicines. They told us that medicines were delivered to the home by the pharmacy each month and were checked in to make sure they were correct. Records of ordering and disposal of medicines were kept in an appropriate manner. The registered manager told us they checked these against the medicines received from the pharmacist. These systems helped to ensure people received their medicines safely.

People were prescribed medicines on an 'as required' basis, however 'as required' guidelines were missing for some people who used the service. This meant staff did not always have clear instruction they needed to administer medicines. The registered manager told us people did have these guidelines but they must have been misplaced. They told us they would take immediate action to address this.

We noted that staff kept a record the temperature of room in which medicines were stored and on occasions this was at the maximum temperature of 25 degrees Celsius. If medicines are not stored at the correct temperature they can lose their effectiveness. We pointed out our findings to the registered manager who said they would monitor this and take any action necessary.

Inadequate

Is the service effective?

Our findings

Records examined and discussion with staff identified that staff had not consistently received supervisions and appraisals from 2014 to the date of the inspection. The registered manager told us staff should receive supervision every other month. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We looked at the supervision records of one nurse and there was no evidence to support they had received supervision in 2014 and 2015 and had only received one supervision in 2016. Other records identified supervision was infrequent.

We looked at five staff records and only one of the five staff (a nurse) had received an annual appraisal. In addition the nurse's file contained no evidence to confirm they had received clinical supervision or were supported to meet their revalidation requirements.

Out of the 31 courses listed we found that one of the night staff members had only completed eight of these courses. This was concerning as they had been expected to work on nights with no senior member of staff or nurse on duty. They had completed Deprivation of Liberty Safeguard (DoLS), equality and dversity, moving and handling, challenging behaviour, gastrostomy, ventilator, first aid and fire training. The care staff working overnight had not completed the registered provider's epilepsy training and two staff had not completed dementia training yet they were providing support for people with these conditions. The registered provider told us after the inspection that ventilator training was no longer needed as that training was specific for an individual person. At the time of the inspection people were not using a ventilator. This training will be provided should an individual be assessed as needing a ventilator.

We reviewed the training matrix for the day staff and found that none of the nurses were qualified first aiders and only 11% of care staff had this qualification. We found that despite the fact that one person who had a tracheostomy received respite care none of the staff had received training around using the suction machine or cough assist. Only one staff member had received any training around tracheostomy care.

Although staff were routinely using physical interventions only 60% of staff had received training around using physical interventions. This type of training needs to be provided by an accredited trainer and annual refresher training is required. We found that for 67% of the staff who had received physical intervention training this was over a year ago. The registered provider told us further sessions had been booked. From a review of the training matrix we found that only 70% of staff had received moving and handling training.

The matrix showed that only 37% of staff had received training around gastrostomy care, however, some of the people who used the service were fed via a PEG (Percutaneous Endoscopic Gastrostomy). This is a way of introducing foods and fluids directly into the stomach and one person on occasions tried to remove the PEG.

This was a breach of Regulation 18(1) and (2) (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us some of the training provided was online and that they could do the course in work time. Also some of the courses were provided by external trainers and they found this mix of training was beneficial. One staff member said, "I have enjoyed the training and have learnt a lot." Another staff member said, "The training has been really good and informative."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The care records we reviewed contained limited assessments of the person's capacity to make decisions. We found that although the staff had recently received MCA training they did not understand the requirements of this legislation and what actions they would need to take to ensure the home adhered to the code of practice.

We found that one person was supported on their own on the first floor of the service. The only time they left was first thing on a morning to go into the garden before the other people got up. Staff told us that this detention and restrictive practice had been agreed via a best interest decision. However, the registered manager told us the person had capacity and chose to live in this restrictive environment. They stated that they were not locked in the unit as they had worked out how to use the release button. This person did have a DoLS authorisation but there was no condition in place authorising the isolation of the person from other people who used the service. By virtue of the DoLS in place it would suggest that the person did lack capacity to agree to constant supervision and not being able to leave the home. However, we could find no capacity assessment for the restrictions in place on this person or any best interest decision about staffing levels and not being allowed to leave the unit. From our discussion with the registered manager and staff we found they were not considering the impact of their practices on this person's human rights.

We found that care records did not describe the efforts that had been made to establish that the least restrictive option for people was followed and the ways in which staff had sought to communicate choices to people. There were no records to confirm that 'best interest' discussions had taken place with the person's family, external health and social work professionals or senior members of staff. Staff had failed to ascertain the legal status of family members when making decisions for people who used the service. No information was available to determine if relatives had lasting power of care and welfare or had been appointed as a deputy by the Court of Protection. Staff we spoke with were unaware of the restrictions on a person's ability to make decisions for others and the need to have the legal authority to make care and welfare decisions

From a review of another two people's care records we found that although staff felt they lacked capacity to make decisions no action had been taken to complete capacity assessments. Both these people had DoLS authorisations in place and therefore we would expect that capacity assessments were completed. Also one person's DoLS authorisation required that capacity assessments were completed and the other person stated staff must ensure the person was cared for in the least restrictive environment. We found that there were no measures in place for staff to ensure they met these conditions.

This was a breach of Regulation 11 (Need for consent) and 13(5) (Safeguarding people from abuse and

improper treatment); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the home's menu plan. The menus provided a varied selection of meals. Staff told us menus had been devised with people who used the service. We saw there were choices at each meal time and people were encouraged to be involved in food preparation and cooking.

One person told us staff were successfully supporting them to lose weight, they smiled as they told us their total weight loss. At breakfast they chose to have melon and staff helped them to prepare this. We saw that staff encouraged this person to assist with the preparation whilst keeping them safe with the knife they were using. The person was proud of their achievement and staff complimented them on this.

Another person was seen to help with the preparation of their lunch. Staff encouraged independence with the opening of packaging but kept them safe when using the kettle. We saw how this person was used to being in the kitchen area as they knew where all the crockery and cutlery was. They also helped themselves with bread to go with their meal.

We observed the lunch time of some people who used the service. Lunch time was relaxed and people who were able told us they enjoyed the food that was provided. Those people who needed help were provided with assistance. We asked the registered manager if people (who were permanent) had undergone nutritional screening to identify if they were malnourished, at risk of malnutrition or obesity. We saw records to confirm people were weighed on a regular basis, however nutritional screening was not taking place. Discussion took place with the registered manager about the Malnutrition Universal Screening Tool (MUST) to assess people. This is an objective screening tool to identify adults who are at risk of being malnourished. The registered manager said that they would speak with senior staff and introduce nutritional screening.

We saw records to confirm that people had visited or had received visits from the dentist, optician, chiropodist, dietician and their doctor. Staff told us the dentist they visited had a hoist, which meant that people could be transferred into the dentist chair. They told us they booked well ahead with appointments so they ensure they got this room. People were supported and encouraged to have regular health checks and were accompanied by staff or to hospital appointments. One person told us, "I see the doctor when I'm poorly." Staff told us they knew people very well and could often tell from their non-verbal communication if people were unwell. They told us they wouldn't hesitate in contacting health care professionals for advice or to visit.

We saw that people had a hospital passport. The aim of a hospital passport is to assist people with a learning disability to provide hospital staff with important information they need to know about them and their health when they are admitted to hospital. Hospital passports contained information that would help to ensure that care and treatment was provided in a way that the person would want it to be.

Requires Improvement

Is the service caring?

Our findings

The inspection of the service identified numerous failings, which posed as a significant risk to the health and wellbeing of people who used the service. Nurses had not been on duty 24 hours a day and we could not determine if people had received their one to one or two to one care. Activities were limited, staff were not trained to support people who used the service safely and supervisions and appraisals were out of date. Care records and risk assessments were insufficiently detailed and although staff had recently received MCA training they did not understand the requirements of the legislation and actions they must take to adhere to the code of practice. In addition quality monitoring was poor. Staff failed to recognise when safeguarding concerns would be considered to be abuse and therefore needed referring to the local safeguarding team. Staff kept an individual record of any incidents involving people who used the service. However, incidents were not analysed. This meant that people did not benefit from a caring culture as a result.

Relatives told us that they generally found the staff to be caring, kind and helpful. One relative shared concerns with us about the attitude of one of the care staff. The relative told us these concerns had been shared with the registered manager because they found the person who used the service to be distressed by the attitude and approach the care staff member adopted. We raised this with the registered manager who told us they had looked into the matter previously but had not found any evidence to confirm the staff member was deliberately trying to upset people. They had discussed with them good customer care practices. The registered manager undertook to complete further investigations.

We reviewed written feedback from relatives and professionals and found they were complimentary about the staff team. Comments included, 'The service you give is great.' And, 'I visit often and always find staff have a very positive and professional attitude.' And, 'We are both really pleased with [name of person who used the service] move to the home.' And, 'The ICT team have enjoyed supporting staff in meeting client needs. Staff should be really proud of the service you provide your clients. You are all a great team.'

During the inspection we spent time observing staff and people who used the service. Throughout the day we saw staff interacting with people in a very caring and friendly way. We heard staff speaking to people about everyday life. Staff took an interest in what people had to say and listened. Staff were respectful when speaking with people. For example when a person who used the service returned from their weekly weigh in staff said, "Are you wanting to tell me how you got on with your weight or don't you want to tell me?" The person who used the service smiled as they told them how they had done at their weekly class. One staff member spoke to a person about their family and what they were going to do that day.

Before care and support was provided staff talked with people and explained what they needed to do, for example, when performing a care task or asking people to sit at the table as their lunch was ready. Staff were caring when one person who used the service hurt their hand when using their wheelchair. Staff rubbed the person's hand and provided comfort and reassurance. These examples showed that staff were caring.

Staff treated people with dignity and respect. Staff were attentive to people who used the service. Staff told

us how they respected people's privacy. They told us how they always knocked on people's doors before entering and made sure they were covered with towels when they were providing personal care. They told us how important it was to ask the person's permission before providing care and to tell them what they were going to do. Staff supported people with their personal care in a discreet and dignified way. The staff we spoke with demonstrated a warm and genuine regard for the people who used the service.

We saw that people had free movement around the service and could choose where to sit and spend their recreational time. We saw that people were able to go to their rooms at any time during the day to spend time on their own. One person who used the service told us, "I sometimes come to my room."

Staff said that where possible they encouraged people to be independent and make choices such as what they wanted to wear, eat, and drink and how people wanted to spend their day. We saw that people made such choices during the inspection day. Staff told us how they encouraged independence on a daily basis.

At the time of the inspection none of the people who used the service required the support of an advocate. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. The registered manager was aware of action to take should advocacy be needed.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we reviewed the care records of three people who used the service and found two records were very person-centred and contained a great deal of information. One of the care records described the help they needed for bathing and dressing. The plan detailed that the person had limited movement in one arm and to encourage independence soaps and shampoos were put on a face cloth and given to the person. The plan also detailed how the person had sensitive skin and not to use perfumed products. Another care plan provided step by step instructions for mobility. Detailed care plans helped to ensure people received the care and support they needed. However, one person's care records were incomplete. The person had been at the home for several months and presented with behaviours that were very challenging. We saw some mention of behaviours that challenge in care records but they did not outline the extent of these or what action staff were to take when supporting with the person. We found that the person's care records failed to provide sufficient information to enable staff to provide safe care and treatment. We found the lack of information around how to manage the behaviours that were challenge left the person and staff at risk of being injured. We received an updated behaviour management plan after the inspection.

This was a breach of Regulation 17 (2) (c) (Good governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that people were involved in activities and outings. We were told that people liked to go shopping, bowling, to the cinema and take part in arts and crafts. One person who used the service attended college for one day a week to take part in a healthy eating course.

During the inspection we saw staff help one person to do a jigsaw and for another to look through some cds so they could choose the music and songs they wanted to listen to. We saw that two people who used the service spent time in the sensory room. This is a special room designed to develop a person's sense, usually through special lighting, music, and objects. We saw from the expression on the person's face that they were enjoying the relaxing music and lighting. We saw that another person was so relaxed they had fallen asleep. One person went out to the cinema with their personal assistant who was not employed by the home. The person was unable to communicate verbally with us but smiled with excitement when the personal assistant told us the film they were going to see. And the family of another person who used the service took them out for the day. However, on the day of the inspection we saw no evidence to support that activities had been planned for the person cared for on the first floor. And for another person they spent most of the time on their own in the lounge enjoying themselves with tactile sensory items. We saw that staff only interacted with the person on one occasion other than at meal times and when they did the person responded positively. The registered provider told us after the inspection that this person chooses the level of engagement they want from staff.

The relatives we spoke with told us that they had little information about the activities people undertook. We reviewed the written feedback relatives and professionals had provided to questionnaires. This showed the same theme of concerns around the level of activity people were engaged in. People said 'From a carer's

perspective I feel I am not really aware of what [name of person] has been involved in.' And 'I have visited on many occasions and feel the staff do not facilitate many activities outside the kitchen. I do not see any evidence of them taking my client outside of the home.'

One person had been coming to the home for respite care for eight months. The person was accompanied by their own nurse with the intention that nurses employed by the registered provider would eventually take over this care. Staff at the service did not ask the person or nurse to participate in activities or engage in much conversation. If staff do not participate in this person's care then it is unclear how staff employed by the registered provider would meet their needs.

This was a breach of Regulation 9 (3) (a) (Person Centred care), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were shown a copy of the complaints procedure which gave people timescales for action and who to contact. The majority of people who used the service were unable to complain verbally, however staff told us they carefully watched people's body language for positive and negative responses to areas such as food, drinks, activities and outings to determine if people were happy. The registered manager said that they spoke and observed people on a daily basis to make sure they were happy.

Discussion with the registered manager during the inspection confirmed that any concerns or complaints were taken seriously. Relatives told us that staff and the registered manager were approachable and they wouldn't hesitate in speaking with them if they were unhappy.

Inadequate

Is the service well-led?

Our findings

The service employed a registered manager who had worked at the home for some time but who had only become the registered manager in April 2016.

We looked at the systems in place for monitoring the quality of the service. The registered provider had systems for monitoring and assessing the service, however these were minimal and did not identify the concerns we identified at the inspection of the service. The registered provider had completed surveys with relatives and professionals but there was no evidence to show that feedback from these was used. For example, a number of surveys detailed concerns about people's access to meaningful activity but we found no evidence to show this had been considered and staff changed their practices to ensure activity was more meaningful.

Also the registered provider had not identified that staff failed to understand the requirements of the MCA and were restricting a person who used the service upstairs without considering the effect on the person or if they were appropriately placed.

We asked for, but were not provided with, admission criteria so we could not see how staff at the home determined that people's needs could be met. Also we found no evidence to show that staff closely considered the compatibility of people before offering them a place at the home. We saw this lack of clear guidance led to people being admitted who would target the less able people who used the service. The result of this had been one person being restricted upstairs. None of the information we saw showed the registered provider had picked up on these difficulties.

We found that two of nurses had left and this meant the home only employed three nurses, one of whom was the registered manager.

We found that nursing staff had had not covered night shifts for two years and more recently nurses were not covering some of the day shifts. When we initially queried this, the registered provider they told us that people who used the service did not require nursing care. The registered manager did not have copies of the placing authorities contracts so could not readily confirm this was true. The registered manager was unable to get a copy of these from the head office so had to contact the placing authorities to get copies. When they did obtain the information it showed that there was an expectation that nurses were employed over the 24 hour period. It was concerning that the registered provider had not obtained this information and therefore could not have taken measures to ensure these agreements were met. We found systems for ensuring to meet regulatory and contractual requirements were flawed.

One person had been receiving respite care for eight months. The person was accompanied by their own nurse with the intention that nurses employed by the registered provider would eventually take over this care. This person required nursing care 24 hours a day. Nurses had not been on night duty for over two years which meant that nursing staff had not had the opportunity to work with the person's own nurse and gain experience and knowledge about how to meet the person's needs.

We asked the registered manager for audits and performance monitoring information. We found that no audits and checks were completed. The only overview of the performance the registered manager completed was via the provider monthly visit record. This provided minimal information. It was concerning that the registered manager was asked to complete this document, as it meant that the registered provider was not independently checking that the home worked in line with their expectations.

We found that there were no effective systems in place to ensure the registered manager and registered provider ensured the service provided safe and effective care and treatment.

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

Staff told us they felt valued and supported by the registered manager. One staff member said, "[Name of registered manager] is a really good manager. She is a hands on manager and you can go to her with any issues." Another staff member said, "[Name of registered manager] is so supportive and works down here with the residents. She is very approachable and easy to talk to."

The registered manager had worked at the service since it opened but had only been the registered manager since April 2016. The registered manager told us that they had an open door policy in which people who used the service, relatives and staff could approach them at any time. This was confirmed by the people, relatives and staff we spoke with.

Staff told us they had regular meetings in which they were encouraged to share their views. They told us that staff worked well as a team. One staff member said, "This is a really good staff team. Everyone is really friendly and there is a good skill mix."

The registered manager told us there were not any formal meetings for people who used the service as many of the people had complex needs and were unable to communicate verbally. Staff told us they would observe people's body language and actions to find out if people were happy. The registered manager told us those people who were able to communicate were encouraged on a daily basis to share their views.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Activities for people who used the service were limited.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not understand the requirements of the Mental Capacity Act 2005 and associated codes of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has not prevented people from receiving unsafe care and treatment. Risk assessments were insufficiently detailed. The registered provider had not done all that was reasonably practicable to mitigate risks as incidents were not analysed to prevent the risk of re-occurrence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff failed to recognise when incidents would

be considered to be abuse and therefore need referring to the local safeguarding team.

The registered provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005 code of practice. Mental capacity assessments were not in place and best interest decisions were not available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was no evidence to confirm servicing of the fire alarm system.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Some water temperatures were low and below the recommended level for the prevention of legionella. Care records were insufficiently detailed to enable staff to provide safe care and treatment. Quality monitoring systems were minimal and ineffective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified staff to meet the care and treatment needs of people who used the service. Registered nurses were not on duty 24 hours a day. Staff had not consistently received supervisions and appraisals.

Staff had not completed all statutory and mandatory training as defined by the provider for their role. In addition training identified as necessary to fulfil their role and necessary to meet the needs of people.