MacIntyre Care

Rowan Close

Inspection report

10-11 Rowan Close
Bursledon
Southampton
Hampshire
SO31 8LF

Tel: 02380407870
Website: www.macintyrecharity.org

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

Summary of findings

Overall summary

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.

Rowan Close is a 'care home'. People in care homes receive accommodation, nursing and/or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rowan Close provides accommodation and personal care for up to six people living with a learning disability, physical disability and autism. The home is positioned at the end of a cul-de-sac within walking distance of local shops and amenities. The accommodation is in a single storey bungalow and comprises two lounges, both overlooking the garden and one with sensory facilities. There are two kitchen/diners, one with accessible work surfaces for people using a wheelchair. People's bedrooms are accessed by a central corridor.

At the time of our inspection six people were living at the home.

The inspection was unannounced and was carried out on 31 January & 2 and 9 February 2018 by one inspector.

We identified a number of serious concerns during our inspection and made several safeguarding referrals to the local authority following our inspection. The Head of Operations visited the home on the third day of our inspection and told us they would put an action plan in place. This was sent to us following our inspection. The provider had also employed a consultant to help support the registered manager and a

senior manager to identify areas for improvement.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. However, we found people living at Rowan Close were not always offered choices or supported to experience inclusion.

The culture within the home was not open, transparent or supportive. The home was not well led and the provider had lacked oversight of the culture that had developed within the home. Concerns raised by staff had not been listened to, investigated and responded to effectively. Staff did not feel respected, valued or listened to and no longer felt able to raise concerns and issues for fear of recriminations.

Medicines were not managed safely. There were numerous issues with the stockpiling and unsafe storage of medicines, and large quantities of unused medicines were found in boxes, cupboards and drawers with no audit trail. The provider could not be assured people had received their medicines as prescribed.

Risks were not always safely managed. Unsafe and unsuitable foods were prepared in a way which increased people's choking risks. Risk assessments had not always taken place before community activity as required in people's support plans. Equipment checks had not taken place or were ineffective leading to the use of unsafe and potentially unsafe equipment.

Not all staff had completed the required training to ensure they could meet people's needs effectively. Staff were not trained appropriately or in a timely way to manage a new resident's specialist feeding equipment. Staff supervision had not taken place for all staff and no staff had received an appropriate appraisal.

Staffing was not sufficient or appropriately deployed to meet people's needs. Staff worked in a way that was task focussed. They did not have time to sit and chat with people or meet their social/emotional/recreational needs.

The provider could not be assured that all incidents, accidents or near misses had been reported or acted upon. Incidents and near misses that we observed or were told about during our inspection had not been recorded.

Assessments were not always carried out effectively and information was not always communicated to staff in a timely way to ensure they knew how to provide care and support for people when they moved in to the home.

The provider could not be assured healthcare recommendations were always followed. There was evidence of some health referrals and input from GPs, dentists and district nurses. However, follow up actions were not always recorded and staff were unable to say if these had taken place.

People were not supported to follow a balanced diet and the quality of food offered to people was poor. Support plans did not contain information about people's food likes and dislikes. There was some evidence

that this had started to be addressed by end of our inspection.

People's rights had not always been protected because the registered manager had not always followed the principles of the MCA 2005. MCA assessments and best interest decisions had not been recorded for most significant decisions or restrictions such as bedrails and lap belts.

People were not always supported to access their community to reduce isolation. They did not always receive care that was responsive to their needs and were often not supported to follow their support plans, interests and community activities due to lack of staffing. One person had not been supported to maintain relationships with people that were important to them leading to isolation from their community. Their communication needs had not been addressed as English was not their first language.

There were no recorded complaints and the Head of Operations was not aware of any although they could not be assured there had not been any complaints or that they had not been reported.

Staff did not feel involved in developing the service. They told us the registered manager did not delegate anything, was not responsive to feedback and did not empower the staff to share ideas. Senior staff had stood down as they were not enabled or allowed to carry out their senior roles.

Systems to monitor and assess the safety and quality of the service were in place, however they were not always effective. Many of the issues we found during our inspection had not yet been identified by the provider. The Head of Operations told us they had introduced a consultant and senior staff member into the home to help support the manager. They later told us they had also started to identify some concerns and shared these with us throughout the inspection. However, systems and processes required significant improvement to detect warning signs sooner in order to prevent such a decline in service.

People's records were often out of date and inaccurate. There was no audit trail for medicines that were unused. The registered manager filled in gaps in witness charts retrospectively and we could not be assured all staff could remember what they had witnessed three weeks earlier. Support plans and other records were cut and pasted, and did not always reflect individual people's needs. Management record keeping was disorganised and not accessible. The registered manager was not always able to provide information about the running of the home when requested.

Staff were kind and caring in their interactions with people. Staff knew people very well and understood their behaviour and body language to help support their communication. Staff understood where people wanted private time and respected this.

Relatives felt welcome and could visit any time. People and their families were involved in making decisions about their care, as much as they could be.

The environment was all on one level, purpose built and fully wheelchair accessible for the people who lived there.

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.

Medicines management was chaotic and unsafe. The provider's policy in relation to the ordering, storage and disposal of medicines was not followed.

Individual risks were not always adequately assessed and mitigated which put people at risk of harm. There were not always sufficient staff on duty with the right skills at the right time to meet people's needs.

Staff told us they understood how to identify and report any concerns if needed. However, none of the concerns we found had been identified and reported as required. The provider could not be assured that concerns would be acted on appropriately as staff told us they did not feel listened to by the registered manager.

Recruitment procedures ensured only suitable staff were employed.

Is the service effective?

Inadequate

The service was not effective.

People's rights were not protected because the registered manager had not always acted in accordance with the MCA 2005 and DoLS.

Staff had not all received appropriate training, supervision and appraisal to support them in their roles.

People were not supported to eat and drink a varied diet that met their dietary needs and preferences although this was improving.

People had access to health care services to support them to maintain their health and emotional wellbeing most of the time, although this could not always be evidenced.

Is the service caring?

Good

The service is caring.

There was a calm and relaxed atmosphere in the home. Staff were patient and kind towards people and respected their privacy and dignity.

Staff knew how to communicate with people in different ways which met their individual needs.

Relatives were welcome to visit at any time which helped ensure people maintained important relationships.

Is the service responsive?

Requires Improvement

The service is not responsive.

People had support plans which had been developed with them, their relatives and other people involved in their care. However, people were not always supported in line with their support plans to follow their interests and hobbies and reduce social isolation. People were not always supported to maintain links with their own communities and cultures.

People had access to an easy read complaints procedure, which included pictures and photos, and relatives told us they knew how to make a complaint. The operations director was not aware that the home had received any complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The culture within the home was not supportive, open or transparent. Staff did not feel listened to or encouraged to contribute to the development of the service. Senior staff had stepped down as they were not empowered or enabled to carry out their duties.

Record keeping was disorganised. Records were not always up to date, complete or accurate and records were not always accessible and available to staff who needed them.

Systems were in place to assess and monitor the safety and quality of the service although these were not always effective and had not identified most of the concerns we found. The provider had recently put senior staff in the home to identify

where improvements were needed and develop an action plan.

Relatives had regular contact with the home and felt able to share their views about the service if and when they wished to do so.

Rowan Close

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 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.

The inspection was carried out on 31 January, 2 & 9 February 2018 by one inspector. The inspection was unannounced.

Before the inspection we reviewed all the information we held about the service including previous inspection reports and notifications. Notifications are events that happen in the home which the provider is required to tell us about law. We also reviewed the most recent Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

As people were unable to tell us their views, we observed them being supported during the three days of our inspection to help us understand their experiences. We spoke with six members of care staff, a community activities staff member and the registered manager. We spoke with a senior manager and independent consultant who were working in the service to support the manager and identify areas for improvement. We also spoke with the Head of Operations throughout the inspection and during the feedback session on the final day. We received feedback about the service from two people's relatives and one healthcare professional.

We looked at each person's care records and pathway tracked three people's care. Pathway tracking enables us to follow people's care and to check they had received all the care and support they required. We looked at records related to the running of the home, including incident and accident records, medicines records and systems for monitoring the quality of the service provided.

We last inspected the home in October 2015 when we rated it as good.

Inadequate

Is the service safe?

Our findings

Relatives told us they thought their family members were safe at Rowan Close. One relative told us, "[Our family member] used to come home. They were always happy to come back here. We have no concerns." Another relative told us, "I'm always very happy with the way [my family member] is looked after."

Although feedback we received was positive, we found a number of serious concerns which meant the provider could not always ensure the safety and welfare of people. Following the inspection we made a number of safeguarding referrals to the local authority safeguarding team.

Medicines records were not managed in a way that ensured people received their medicines safely. Each person had a medicine administration chart (MAR). We noted hand written entries had been made on some people's MARs. These were not always obvious and could be easily missed. Hand written entries were often unclear and had not been signed or dated to say who had authorised the changes, who had made the entries and they had not been witnessed by a second staff member. This is good practice as described in the NICE (National Institute of Clinical Excellence) guidelines when transcribing to ensure each hand written entry is double checked and correct. Where people required their medicines to be crushed, there was no record that this had been authorised by a GP or discussed with the pharmacy to confirm the safety and effectiveness of the medicines would not be affected by altering their form.

Medicines were not managed in line with best practice or with the provider's policy. Systems for ordering, storage and disposal of medicines were unsafe and chaotic. There was poor stock control which led to excessive supplies of medicines on the premises. The medicine cabinet was disorganised and over full. On opening the medicine cabinet, a basket of medicines fell out onto the floor. The staff member told us it was because there was too much stock in the cabinet. Staff told us the local pharmacy refused to take unused medicines back. The registered manager had not resolved this with the current pharmacy, leading to a stock pile of medicines. Temperatures had not been recorded in the medicine cabinet since July 2017 so the provider could not be assured that medicines were stored in line with the manufacturer's guidelines and remained effective and safe to use.

There were some medicines left over in people's medicine's packs in the cabinet. Their MARs did not always say why these had not been given or were not required that day. The provider could not therefore be assured there was a valid reason these had not been given and had not just been missed. People's topical creams were left in the communal bathroom. A number of these creams were not labelled to say who they belonged to or when they were opened so there was a risk that people might be given the wrong creams or that they were no longer safe to use. For example, one pot of cream had been dispensed in October 2013. There was no date of opening on it. Another pot of cream was found in a basket next to the bath. It had no label on it and no date of opening. A tube of lubricant had no label and no date of opening.

On the third day of the inspection, the senior manager found a large cardboard box full of unused medicines under some cloths in a cupboard. They also found loose tablets belonging to people living at the home in a carrier bag in the registered manager's desk drawer. The consultant also confirmed they had found

medicines in other cupboards where they should not have been stored. There was no audit trail for these medicines and no stock reconciliations had been completed which meant it was not possible to know if all of these unused medicines could be accounted for.

We asked the provider to report this to the GP and the local authority safeguarding team immediately as it was not possible to ascertain if these medicines were excess stock, no longer required, or whether people had not received their medicines as required. Since our inspection the local authority safeguarding team have asked the provider to investigate this and to refer each person to their GP for a review.

Staff told us they recognised that medicines were not effectively managed but said the registered manager would not allow staff to have any involvement with this. When we asked to see audits of medicines, which might have identified these issues, we were told that audits of medicines had not been carried out. The senior manager told us they had recently started a medicines audit but had decided to start from scratch with implementing new medicines procedures. Following the inspection the provider sent us a medicines audit which had been completed in June 2017. Numerous issues had been identified; however, appropriate action had not been taken to address most of these issues which remained a concern at the time of our inspection.

The provider could not be assured that people received their medicines from staff who were appropriately trained and assessed for their competency to do so. Training records supplied by the provider showed that only seven staff members had received training and one of these was overdue to be refreshed, although all but one of the staff had completed an annual competency assessment to administer medicines in January 2017. However, the registered manager had not been assessed for their own competency even though they carried out competency assessments on staff. The provider could therefore not be assured that staff were assessed appropriately by a competent person.

The registered manager had not followed the provider's policy in relation to managing medicines.

Failure to manage medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Individual risks relating to people's daily lives had sometimes been assessed and measures were in place to mitigate some risks. However, other risks had not been identified and mitigated. For example, people who had a specific health condition which put them at risk of choking required their food to be pureed to a specific texture. On the first day of our inspection people were given pureed beef burgers and baked beans for their lunch meal. These foods are deemed unsuitable for pureeing in the guidance produced by the NHS Trust and therefore increased the risk of choking for people.

People's support plans required that a risk assessment was carried out before they participated in outside activities. We noted that people had not been outside of the home very much during January 2017. We spoke with the registered manager to find out why this was the case. We have written about this in more detail in 'Responsive'. Following our discussion, the registered manager reacted inappropriately by immediately instructing staff to take people out for a walk in their wheelchairs. It was a bitterly cold day. The surrounding streets were quite hilly and one staff member, who was required to push a person in a heavy wheelchair, was of small stature. The registered manager had no regard for this requirement and did not assess the potential risks at that time.

The risks associated with the use of some equipment had not always been identified and actions taken to mitigate these. For one person who used a wheelchair to aid their mobility, we saw that the back of the

chair was broken. One side had become completely detached and was secured with duct tape which had also become loose and was unsafe. This had been identified in an on-going audit since July 2017. A staff member told us, "I did a referral for [The person's] chair a year ago. I gave it to [The registered manager]. They said they would put it through." They went on to say they weren't sure if this had been actioned, although there was a hand written note on the audit that the issue had been referred to the wheelchair service for repair. Following the inspection the provider sent us evidence that the referral had been made in June 2017. However, the referral requested an assessment to check the wheelchair was still suitable. It did not explain the wheelchair was broken and had not been marked urgent. The referral had not accurately reflected the problem, had not been chased up and the person continued to use their broken wheelchair throughout this period.

We noted on the second day of our inspection that the hoists had not been serviced since April 2017. The registered manager confirmed this should be carried out every six months and should have been serviced in October 2017. This meant people had been hoisted, since October 2017, using hoists that had not been checked to ensure they remained safe to use. We brought this to the attention of the registered manager who arranged for these to be serviced the same day.

The registered manager had not followed the provider's policy in relation to the management of health and safety and risk assessment.

Failure to adequately assess risks and take mitigating action was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

There were insufficient numbers of staff, with the right skills and experience, deployed to meet people's needs in the home and in the community. On the first day of our inspection we noted that three people were still in bed at 11.45am. We discussed this with a staff member who told us there was not a trained member of staff on shift in the afternoon to administer specific medicines so these had to be given in the morning instead. Due to the nature of these medicines, people had to remain in bed for a period of time after receiving them. We spoke with the registered manager about this. They told us the staff had made this decision so there would be a sufficient time lapse after receiving their medicines for people then to be able to go out in the afternoon. The minibus driver only worked on that day and staff did not want people to miss the opportunity to go out. We asked staff if this situation had happened before. They told us it had, although not very often. The lack of specifically trained staff resulted in three people having to stay in bed until lunchtime.

We noted that the registered manager often put themselves on the rota to cover a sleep in shift at night. They were not physically fit and staff raised concerns that as the second member of staff at night, the registered manager would be unable to respond effectively to any emergencies that might arise that required physical assistance. There was no risk assessment in place to say how this would be managed.

We observed staff providing care and support and noted that this was very task focussed. We consistently observed people sitting in their wheelchairs, alone or in small groups, in the lounge or sensory room. On most occasions we noted there were no staff present. Staff told us there were enough staff to provide basic care but they didn't have time to sit with people or take them out into the community. One staff member told us, "It's hard to do in-house activities. I can't bear seeing them just sat there." Another staff member told us, "We haven't got enough staff to deliver quality care. We don't have time to do the day to day things let alone spend one to one time or socialising." Two relatives told us they thought there were sufficient staff for care but not for social needs. They said, "They do their best with limited staff."

The staffing levels assessment was last carried out in March 2017. At this time there were only five people living at Rowan Close. The staffing assessment was not reviewed to take account of a sixth person moving in to the home in October 2017 and staffing was not increased to accommodate this. Staff showed our inspector the care a person required to meet their complex feeding and medication routine. They were concerned that they didn't have the time they needed to properly care for them and the other people living in the home. One staff member said, "It was frantic. We had to rush the guys [people]." They went on to say they were concerned that the other five people were not getting enough of their time.

Failure to deploy sufficient staff with appropriate skills and experience was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Safeguarding concerns were not always identified or reported to the appropriate agencies. We spoke with staff and they told us the signs they would look for which might indicate that abuse was taking place. They knew how to report any concerns, including to outside agencies such as the local authority and the Care Quality Commission (CQC). However, none of the safeguarding concerns we found had been identified by the registered manager or reported to the local authority or to CQC. Staff told us they did not feel listened to by the registered manager so we could not be assured that any reported concerns would be acted on appropriately.

According to training records supplied by the provider, only five out of seventeen staff had received training in safeguarding people. The provider required annual staff competency assessments in safeguarding to be competed; however, these had not taken place.

Failure to safeguard people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safeguarding.

Systems were in place to manage the safety of the environment. Fire alarm systems, fire checks, gas safety and water safety, such as cleaning of shower heads and water temperatures were tested regularly by the premise's landlord.

The home had an emergency plan which provided guidance to staff in the event of an unforeseen emergency. Individual emergency evacuation plans were in place for each person which detailed the support they would require in the event of leaving the home in an emergency situation.

Recruitment processes were in place which ensured only staff suitable to work in a social care setting were employed. There had only been one new staff member recruited since our previous inspection. Their recruitment records included an application form detailing their employment history. Satisfactory checks had been completed including criminal records checks and proof of identity.

Inadequate

Is the service effective?

Our findings

Relatives told us they were satisfied with the health care support their family members received. One relative told us, "They are open with us and keep us informed. They pick up quickly if [our family member] is unwell." They went on to say, "Staff know [our family member] very well. New staff can't work with [our family member] until they are confident." A health professional told us, "They [staff] look after them [people] very well with excellent care and attention."

Although the feedback we received at this inspection was positive, we found a number of serious concerns during the inspection.

Most people had lived at Rowan Close for many years so initial assessments were not recorded in their care records. However, one person's needs had not been adequately assessed nor sufficient measures put in place before they moved into the home to ensure their needs could be fully met by staff who had appropriate knowledge. They had been admitted to the home on a short term emergency placement in October 2017. Information had been passed to the registered manager by the local authority learning disability team. However, staff we spoke with told us information had not been communicated to them and they had not been involved in planning the person's transition so they did not have any opportunity to raise questions or concerns before the person moved in. There was no Provider assessment or care plan documentation in the person's care records for staff to refer to. Comments from one staff member included, "I first met the person [when coming on shift] and was told I was taking them out. I hadn't even met [the person]. I was told to get on with it. I didn't have a chance to read the care plan [from the previous placement]." Where staff do not have the opportunity to learn about a person's support needs before providing support, there is a risk their needs might not be met appropriately.

Failure to carry out appropriate assessment of people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care.

Staff had not always received appropriate training to ensure they could meet people's needs safely and effectively. One person required their nutrition and medicines to be provided via their Percutaneous endoscopic gastrostomy (PEG) tube. The PEG was managed via a pump and provided a measured dose of nutrition and medicines directly into the person's stomach. Although staff supported other people with a PEG, they had not used a pump before. Staff told us when the person arrived at the home, information and training had not been provided by the registered manager to the staff to give them the skills and knowledge required to use the pump safely and appropriately. One staff member told us, "There was no handover. A [staff member] from [the person's] old house came the next morning. They were quite happy to show me but it was voluntary."

The provider sent us a training plan which showed that not all of the seventeen staff were up to date with key training the provider required them to do. For example, fourteen staff had completed training in MCA and DoLS. Ten of these staff completed their training between 2010 and 2013. Since then there had been changes to the DoLS legislation following a Supreme Court Judgement in March 2014. The provider required

staff to complete an annual review of MCA, however, only four of these staff had completed this competency review. The provider had not ensured they assessed staff competency in line with their requirements, so could not be assured that staff were up to date with their knowledge. In addition, only five of the seventeen staff were up to date with their health and safety training, and only six staff had completed the provider's 'DNA' training. This is training to provide staff with information about the Provider's values and the approaches they should use to ensure person centred care. Only eight staff were up to date with manual handling and only six staff were up to date with training in risk assessment.

The provider's PIR stated, "Staff receive regular supervision and appraisal." However, we found this was not the case. Staff told us they had supervision but this was not on a regular basis and records of supervisions did not always reflect what had been discussed. Staff also commented that supervision was not always effective as they were worried about raising issues in case this was later used against them. Staff told us they did not have a meaningful appraisal which provided them with an opportunity to discuss their performance and development needs. Comments from staff included, "I was given a sheet [by the registered manager] which was already filled in and told to sign it," and, "I've not had an appraisal in two and a half years. It [appraisal form] was typed up [by the registered manager], printed off and given to me to sign. There was no sit down conversation." Another staff member said, "If you look they will all say the same." We could not gain access to the staff records and asked the provider to send supervision and appraisal records to us following the inspection. Supervision records were sent for only five members of staff, however, no appraisal records were received. The registered manager did not follow the provider's policy in relation to their responsibilities to supervise and appraise their staff.

Failure to provide appropriate training, supervision and appraisal for staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

People's rights were not protected because the principles of the Mental Capacity Act 2005 had not always been followed. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The provider's PIR stated, "We complete MacIntyre's Mental Capacity Decisions form (incorporating a mental capacity assessment and where capacity is lacking, a best interests decision) for people's significant decisions to make sure that people have as much choice and control as possible." However, we found this not to be the case. Mental capacity assessments had not always been completed when required and best interest decisions had not been recorded. We viewed three people's MCA assessments which had been to assess their capacity to make the decision to not be admitted to hospital unless their life was in danger. This included who had been involved in this best interest decision. However, there were no other MCA assessments for other significant decisions in relation to their care or restrictive practices such as the wearing of lap belts or the use of bedrails.

Failure to act in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Need for consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the deprivation of liberty safeguards (DoLS). People had been on DoLS which had expired in 2017. The provider was unable to show us evidence during the inspection that these had been re-applied for.

Following the inspection, the provider sent us further evidence which showed all applications had been submitted before the current DoLS had expired. Two people's DoLS had subsequently been granted and two more were waiting for authorisation. However, the provider could not be assured that appropriate applications had been submitted to cover all restrictions requiring authorisation. Following the inspection, the provider sent us copies of DoLS applications for two people. These described the care and supervision required to meet people's daily needs. However, they did not include any information about the need to implement restrictive practices, such as the use of lap belts and bedrails.

Failure to act in accordance with the MCA 2005 Deprivation of Liberty Safeguards is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safeguarding.

The provider's PIR stated, "We cater for special diets and encourage healthy eating." We found this was not the case. People were not provided with an appropriate choice of nutritious food which met their dietary needs. The menus did not support people to enjoy a healthy, balanced diet.

On the first day of our inspection, we observed people were all given frozen beef burgers which were cooked and served with baked beans for their lunch meal. We looked at the menu and saw the evening meal was fish pie. We went to the kitchen later that day to watch this meal being prepared. Six individual frozen fish pies were removed from the freezer and put in the oven to cook. We looked in the fridge and noted there was no fresh produce, such as vegetables and there was no fresh fruit available for people. The food cupboards were full of tinned meatballs, ravioli and macaroni cheese. The freezer was full of processed foods and frozen vegetables.

Staff told us they were unhappy with the poor quality of the food which they said was all frozen or processed. One member of staff told us, "Often we haven't got the food for what's on the menu. We just have to work with what's in the cupboard and freezer." Another staff member told us, "I can't remember the last time they had fresh fruit and veg….They do sometimes get bananas." Staff told us the registered manager did all the food purchasing so they had no involvement in this. We spoke with the registered manager about the quality of the food. They responded, "Frozen food is as good as fresh." We asked why people weren't given fruit and they told us people couldn't eat fruit as it couldn't be pureed. We challenged this and said many fruits could be pureed especially if they are cooked first. They went on to say, "They do have bananas." We found their response to our concerns about the nutritional quality of food be unhelpful and dismissive.

People's support plans did not include any information about their food likes and dislikes or preferences. We observed everyone was given the same meals and when one person refused to eat their pureed lunch meal, they were offered two yoghurts as an alternative. The staff member told us the person liked to eat cold foods but no cold savoury alternative choice had been made available as a main meal. We were also concerned that the portion size of two yoghurts was insufficient for an adult male's main lunch meal. Although the staff member said they would hand over to the late shift that the person had not eaten much at lunchtime, no additional food or snacks were offered to the person during the afternoon. We later saw the person had become upset and staff were talking to the consultant about what the matter might be. We mentioned the person had not eaten much at lunchtime and they then explored that the person might be hungry.

Failure to meet people's nutritional needs is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Meeting nutritional and hydration needs.

We noted people received drinks throughout the day. These were prepared with appropriate thickeners where required. However, we observed some staff scooping in thickener but not leaving it to thicken up the

drink before adding more thickener. People's support plans referred to thickened drinks being of 'custard consistency' which was subjective and could be interpreted differently by staff.

When we returned on the third day of our inspection, we noted that the consultant and senior staff had made some changes to the menu in the registered manager's absence. Some fresh fruit and vegetables had been purchased and staff had cooked more nutritious meals from scratch using fresh produce. This was a work in progress and we will check to ensure improvements have continued to be made when we return to re-inspect.

People were supported to maintain their health and emotional wellbeing on a day to day basis by staff. There were records showing that people were supported to have routine healthcare visits from health professionals, such as GPs, chiropodists and dentists. Staff identified if people looked unwell and made prompt referrals to GPs for advice and treatment. However, it was not always clear if recommendations and follow up actions had been completed. For example, a GP had requested for one person to have blood samples taken but there was no further record of this. Another person had been referred to a GP because they were not eating or drinking, they were crying and appeared in pain. There were no details recorded to say if they had been seen by a GP or what the outcome was. Staff could not confirm what had been done in either case.

Each person had a 'health action plan' which included information about their health needs, health management plans and details of health professionals who were involved in their care. However, we noted some information in people's records was out of date, and some had been copied and pasted from other people's records. For example, records included the same guidance for staff to make regular checks of people's breasts and testes whether for males or females and had not been adapted to refer to relevant and gender appropriate screening.

The home environment was adapted to meet the needs of people who used wheelchairs. The home was on one level with easy access from the driveway into the home. Corridors and doors were wide enough to comfortably manoeuver people's wheelchairs. There was a sensory room with fish tanks, coloured lights and bubble tubes which provided a relaxing area for people. We noted, however, that this room was also used for storage of wheelchairs and other items which gave a cluttered feel to the room. There was a large bathroom and wet room which enabled people a choice of assisted bathing options. The main kitchen had lowered worktops which were accessible to people in their wheelchairs, although these were rarely used. There was easy access in to the gardens which had a number of sitting areas and sensory items such as mobiles and windmills.

Good

Is the service caring?

Our findings

Relatives told us the staff were caring. One relative told us, "They [staff] are superb. They are very caring. We see quite a few staff. They're always happy. They genuinely care. It's not just a job to them, it's a commitment." A second relative said, "I'm very comfortable with the care [my family member] gets from the staff. They're very caring. They treat [my family member] with such patience and kindness. I'm very aware to acknowledge good care." A healthcare professional told us, "My general view is that these clients [people] are looked after like family members by the staff who are caring for them. They have become very fond of the clients [people]."

Staff knew people very well and we observed them using different methods to communicate with people in a way they could understand and be understood. For example; sign language, objects of reference and pictures. Although opportunities for meaningful interactions between people and staff were limited due to staff numbers, effective communication enabled people to enjoy those interactions to the full. One member of staff told us a person liked to brush their hair. They told us, "I let my hair down when I'm doing a sleep [night shift]. He will brush my hair and then tell me it's messy!" We observed this staff member allowing the person to stroke their hair and talking about how different it looked when it was tied up or loose. We could see the person enjoyed this interaction.

Staff had a very good knowledge of people, including their life histories, the things they liked and didn't like and the people who were important to them. A relative commented, "I'm very happy with the staff. They know [my family member] so well and what their needs are." People's support plans included information about their preferred communication styles and the responses staff should look for to help them understand what people were telling them.

The atmosphere in the home was calm and relaxed. Staff interactions with people were kind and respectful. We observed one member of staff apologise to a person because they had their back to them on one occasion. Staff respected people's privacy and dignity and this was confirmed by a relative who told us, "They always ask, give choices, respect [our family member's] private space." Staff understood people's body language and responded appropriately to reassure them if they were anxious with appropriate touch and gentle voice. Staff knew when to give people space and time. A staff member told us, "I appreciate sometimes they may not feel that great. They're on lots of meds [medicines]. I don't overdo it or get in their personal space."

Staff clearly cared about the people they supported. Comments from one staff member included, "I get satisfaction knowing they [people] are clean and cared for. We all care about them. We want the best for them." Another staff member told us, "They [people] are fantastic, the best. I'm a bit biased obviously. The best way to get to help someone is to get to know them."

People's support plans included information about their character and attributes. For example one person's support plans stated, "What people admire about me. A lovely laugh, beautiful smile." We observed how staff genuinely enjoyed hearing this person laughing and squealing in delight when their parents visited. A

staff member told us, "[The person's] pitch gets higher. It's sheer joy. You can see it and hear it. It's fantastic, it really is." Relatives were able to visit at any time and felt welcomed by staff.

People's bedrooms were decorated to their own tastes and were furnished with their personal belongings which reflected their interests. For example, pictures of favourite TV characters and soft furnishings in their favourite colours.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were satisfied with the support provided to their loved ones and felt involved with planning and reviewing their care and support. One relative told us, "We are always invited to attend reviews. I expect to be at reviews." Another relative said, "We have regular meetings. We are asked our opinions and could raise concerns if we had them."

Whilst relatives gave us positive feedback we identified a number of concerns about the quality of people's lives during our inspection. We observed people spent most of their time inside the home sitting in their wheelchairs, either in one of the lounges or in their own rooms. Sometimes the television or a film was on in one of the lounges but not everyone engaged with this entertainment. We observed one person sat in their wheelchair on their own for long periods of time with nothing to stimulate or interest them.

People were not always supported to maintain their interests and hobbies in line with their preferences and wishes. For example, one person's support plan stated, 'I like to keep busy,' and, 'I like to go out for a coffee everyday if possible. I like to be with staff and to be occupied.' Their preferred activities included shopping, walks on the sea front, golf and bowling. We looked through their daily records for January and saw they had only gone out of the house on four occasions and had not taken part in any of these activities. Another person's support plan stated, 'I like to go out every day. I like being outdoors.' Their preferred activities included cinema, shopping, garden centres and people watching. However, we noted they had only been out on three occasions in January and had not taken part in any of their preferred activities. Following the inspection the provider sent us a record of activities people had taken part in during December. We noted there was a similar level of inactivity in the community.

A staff member told us they were frustrated at the lack of things for people to do. They said, "Not many service users [people] can do a lot of in house activities [due to their restricted hand movements]. Only [Name], he can do arts and crafts. The only change from the TV all day would be to go out, a change of scenery, getting out of the house, to the beach, shopping, for coffee. It's not right." Another staff member told us, "Activities? Mainly TV is most of it." A third staff member told us, "If the weather was nice we could take them for a walk but we're understaffed." We spoke with the registered manager about our concerns. They told us that people had been unwell in January and whilst we saw some references to people being unwell, this did not account for the level of inactivity. They also told us that staff were unwell. Whilst this cannot be foreseen, there should be contingency plans in place to ensure staffing is covered and people continue to receive the support they need, including maintaining activities to an acceptable level to achieve a good quality of life and reduce the risk of social isolation.

Another person had moved to the home on an emergency temporary placement. English was not their first language and this was recorded in their support plan along with their cultural needs. This included how important it was for them to maintain their strong links with their own church. We noted their activity schedule included going to their bible group, tea dance, hydro, having a massage and pamper, going to the cinema, shop and gallery. We noted they had not taken part in any of their preferred activities in January. We also noted that arrangements had not been made for the person to visit their church in the four months

since they had moved to the home. This had resulted in them becoming isolated from their own community and faith.

Staff shared concerns about staffing at a handover meeting. They said two agency staff had been allocated to take two people out in the mini bus. In all, four staff said that one person required two to one support in the community which meant there were not enough staff to provide support to both people. Following the inspection the provider told us the person's local authority needs assessment stated they only needed two to one support for their personal care and did not require this when in the community. They sent us a copy of the assessment which confirmed this. However, this meant that staff did not have a clear understanding of the person's community support needs.

The provider had a policy on the Accessible Information Standard. This aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. However, the provider had not ensured people who spoke English as a second language had access to appropriate communication support. Staff told us they had suggested to the registered manager that one person could benefit from a translator to help with communication and ensure they felt more involved with making decisions about their support. However this had not been followed through.

Failure to provide person centred care which met people's social, emotional, cultural and religious needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care.

People's support was planned with them and with people who knew them well, such as their relatives, staff and relevant health and care professionals. Each person had a keyworker who took a lead role in supporting them and liaising with their family members and advocates when necessary. People's support plans included information about the specific support they required, such as their personal care, mobility and preferred activities and interests. Keyworker's ensured people' personal care and environment were maintained to a high standard. For example, people's personal appearance was good; they were clean and well dressed. Staff checked people's bedrooms were clean and they had sufficient toiletries.

The home had a complaints procedure and there was a pictorial version in the hallway for people to see, which included pictures and symbols, such as an unhappy face. A complaints box was also in the hallway although people would need help from staff to raise any complaints. Relatives told us they would speak to the staff or registered manager if they had any concerns. When asked, the operations director was not aware of the home receiving any formal complaints.

Inadequate

Is the service well-led?

Our findings

Relatives told us they had no concerns about how the home was run. One relative told us, "[The registered manager] keeps in touch all of the time." Another relative told us their family member was settled and happy and said, "It has had a positive effect on us as a family." Relatives told us they had regular contact with the home and therefore had opportunities to provide feedback if and when they wanted to.

The home had a registered manager who had just reduced their hours. On the first day of our inspection we were greeted by an independent consultant and a senior manager who told us they were working at the home to support the registered manager. We also spoke with the Head of Operations who explained they had put in this support for the registered manager. We contacted them again after our first day of inspection to raise a number of concerns. During the course of our inspection, we identified further concerns. On the third day of our inspection we arrived and were told the registered manager was not currently at work. The Head of Operations visited the home and told us that due to the concerns we had raised, they were carrying out an investigation into the way the home was managed. They then told us that they had recently also started to identify some concerns and this was the main reason for the consultant and senior manager being present in the home. The Head of Operations told us, "It's awful. It's very sad that people have got to this stage." They went on to say, "This is not a service we are proud of." They told us the measures they would put in place to address the concerns raised and that these should be able to be resolved quickly. By the end of our inspection we saw that some action had been taken to start to address some of the concerns. Since our inspection, a new area manager has started in post. They have sent us an action plan to tell us they have started to address the issues and how they intend to continue to address the concerns we have raised. We will check to make sure they have met their action plan when we return to re-inspect.

There were systems in place to monitor the quality and safety of the home however, these were not always effective in identifying shortfalls and driving improvement. We asked to see what external monitoring took place by senior managers and were given a copy of a Health and Safety Audit which was carried out in July 2017. Most aspects were fully compliant. However, we were told this was the only audit that had been carried out by an external manager in the past six months. The provider's PIR stated, "We will compile effective action plans from various audits; including the Quality self-assessment, review of complaints, Health and Safety, Manual Handling and hoist and medication." However, we found this was not the case. For example, the hoist servicing had not been identified as being significantly overdue. Serious issues with medicines and risk management had not been identified. Following the inspection, the provider sent us a number of documents to show they had audits in place in line with what they had described in their PIR. Some documentation evidenced that at the time of the audit there had not been any concerns. However, where audits had identified issues, actions had not always been taken to address the concerns and many issues remained outstanding. Systems and processes required significant improvement to detect warning signs sooner in order to prevent such a decline in service.

The registered manager had not created an open and transparent culture within the home and staff were not supported to raise concerns, share ideas or contribute to the development of the home. The provider's PIR stated, "Staff are motivated and clear about their roles; they are trained, supported and supervised

well." It went on, "Staff are encouraged to speak up and contribute positively to the development of the service." We did not find this to be the case. When we gave feedback about some of the concerns, the registered manager was, in some cases, both defensive and dismissive.

Staff did not feel supported and were reluctant to speak up or raise concerns for fear of repercussions. One staff member told us, "We have raised concerns in the past but nothing has happened." Another staff member told us, "We have to do as we're told. We can't raise concerns, can't say anything, we're not listened to. I went above [the registered manager] but it didn't work out how we'd hoped, still not listened to. We have tried in the past, we just shut up now." Other comments from staff included, "It's [the registered manager's] way or no way" and "There's a climate of fear." "Rules come in, the goal posts change. There's no consistency." One staff member added "[The registered manager] also does a lot of good and tries her best but she needs to be in control." Staff gave us examples of the registered manager using their position to punish staff for speaking up, for example taking away their sleep in shifts or not authorising their holidays. Staff told us the registered manager was controlling and wouldn't delegate to senior care staff. This had resulted in senior care staff stepping down from their roles as they were not empowered or enabled to carry out their duties.

Staff meetings took place. These should provide supportive opportunities for staff to share information and good practice. The provider's PIR stated, "Regular team meetings are held and staff views are valued." However, staff did not find the meetings a supportive experience and did not feel respected or valued. One staff member told us, "They are not calm places to be. We have all got similar concerns. If you feel really strongly and you're brave enough to speak up…... [The registered manager] is not always very nice to people [staff]." Another staff member said, "[The registered manager] should listen to staff more about ideas. We just get shouted down."

We could not be assured that all incidents, accidents and near misses were reported which ensured a culture of learning from mistakes, as stated in the provider's PIR. There had only been two recorded incidents. These had been reviewed by the registered manager. However, we observed a number of incidents or near misses during our inspection, or that were brought to our attention, which had not been reported or recorded. For example, medication errors and safe procedures not followed by agency staff when taking people out in the mini bus.

Records were disorganised, incomplete and inaccurate in many cases. The registered manager had filled in gaps in medicines witness charts retrospectively. People's MARs were checked by staff before administering each medicine and signed by staff when each medicine had been given. A second staff member checked that the correct medicines were given and signed a chart to say they had witnessed this. However, on the first day of our inspection we noted there were a significant number of gaps on the witness chart going back several weeks. We mentioned this to the consultant who was working in the service as the registered manager was not present in the home. When we returned on the second day of inspection, the registered manager had signed all the gaps on the chart. We asked them why they had done this as it is falsification of records and can lead to inaccurate records. They told us they had asked the staff who had confirmed they had witnessed all the medicines. Other records issues included; no audit trail for the medicines that were unused and found in a box. Support plans were cut and pasted and did not always reflect individual people's needs. Bath temperature checks were not always recorded. Medicines cabinet temperature checks were incomplete.

The registered manager guided us to the files in their office so we could review everything we needed to see. It was apparent the files were not all up to date. We were unable to find most of the records we wanted. The registered manager told us they were probably on their computer and were able to supply some of the

information we required. On the third day of our inspection, the consultant and senior manager tried to find other documents on the registered manager's system for us. This included a MacIntyre support plan that had been written for a person who had moved into the home in October 2017. This support plan had not been printed off, nor included in the person's care records and so was unavailable to staff. This meant records were not always accessible to the staff who needed them.

The above failings are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good governance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out appropriate assessment of one person's needs. The provider had failed to provide person centred care which met people's social, emotional, cultural and religious needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to always protect people's rights and act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and mitigate risks to people and manage medicines safely,

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 The provider had failed to always identify and report safeguarding concerns appropriately.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to support people to have a balanced diet and had not met people's nutritional needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain oversight of the service. The provider had not kept under review the culture within the home and had not listened to, recorded and responded to feedback to drive improvement. Systems and processes to assess and monitor the quality and safety of the service users, staff and others were ineffective. Risks were not adequately managed and records were not always accurate, complete and contemporaneous.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff deployed to meet people's needs. Staff had not received appropriate supervision, appraisal and training to support them in their roles.