Cliffemount Community Care Limited

Cliffemount Community Care

Inspection report

411 Hale Road
Hale Barns
Altrincham
Cheshire
WA15 8XU

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27 January 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
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

This inspection took place on the 25 and 27 January 2017 and was unannounced.

Cliffemount Community Care is registered to provide accommodation for up to 5 people who require support with a range of complex care needs including personal care. The service states it specialises in supporting younger adults with a learning disability and autistic spectrum disorder to increase their independent living skills. The service is based in Hale Barns, within walking distance of local facilities including, shops, cafes, restaurants, parks and leisure facilities.

At the time of our inspection there were two people living at the home. A third person had moved into the service for three weeks from the 18 December 2016. They had moved out following a serious incident at the service.

The previous inspection was carried out in May 2016 and the service was given an overall rating of Good. The Care Quality Commission had received a serious safeguarding alert from the local authority and brought this inspection forward as a result.

The registered manager of the service had been off work since March 2015. The nominated individual was the acting manager. A deputy manager had been appointed in May 2016, but they had left the service in January 2017. A new deputy manager was in post and we were told they were going to apply to become the registered manager.

During this inspection visit we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to staff training, the recording of controlled drugs, the transition and staff knowledge of the person's needs when they joined the service in December, quality assurance and auditing systems and the openness and integrity of the nominated individual. We also found breaches of the Care Quality Commission (Registration) Regulations 2009 relating to not submitting the required notifications to the CQC. A notification is information about important events which the service is required to send us by law.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The two people living at the service told us they felt safe. Staff knew their needs well and detailed care plans and risk assessments were in place. These included guidelines for staff as to what support people required and what tasks people could complete themselves. Where applicable behaviour management plans were in place, providing details of potential triggers to behaviour and signs for staff to observe that the person was becoming anxious. Ways to reduce people's anxiety and de-escalate potential incidents were recorded.

We were told staff had been trained in the use of physical intervention techniques. However we found that

the nominated individual's accreditation for facilitating this training was not current. The staff had not received the full training course. Therefore they were not fully trained in the use of physical restraint.

We were told staff were completing on-line training workbooks. However we found that the subscription to the training provider's courses had lapsed. Staff had not completed all the required workbooks. This meant staff did not have all the training they needed and their competency had not been assessed.

The nominated individual showed us training certificates for mandatory courses. They said staff had completed these through Leeds City College. However when we contacted Leeds City College the assessor named on the certificates was not known to them and they did not offer all the courses claimed by the certificates seen. The certificates did not have the Leeds City College logo on them.

There were discrepancies between what the nominated individual told us about waking staff being on duty when the third person was at the service and what other staff told us and what the local authority had been advised at the point of commissioning the placement. The nominated individual had told us prior to the inspection there was a waking night and sleep-in staff on duty at night when the third person had moved to the service. During the inspection they said the waking night was only on duty if the person had been agitated during the day. Staff, including the previous deputy manager told us there had only been a sleep-in staff on duty. The rotas only showed a sleep-in staff being on duty.

Following an unsubstantiated allegation against staff the nominated individual took statements from the staff on duty, saying a waking night staff had been on duty when the allegation was made. The previous deputy manager also took a statement from one of these staff members which stated there had only been a sleep-in. During our inspection staff told us only a sleep-in had been working at that time.

This meant we could not have confidence in the information given to us by the nominated individual.

Medicines were safely stored. We saw one medicine administration record which had not been signed for one tablet for a month. We were told that the GP had stopped the medicine and then re-started it. We could not find any evidence of this in the person's care file. Controlled drugs were safely stored; however they were not recorded in a separate log, with a running total of tablets in stock noted as required by law.

A premises audit was completed weekly. However other quality assurance systems were not in place. For example medicines, manager daily record and analysis of antecedent- behaviour-consequence charts to look for patterns and learn from potential triggers.

There was only a three week assessment and transition period for the third person who moved to the service in December. The person had complex needs and a history of challenging behaviour. Comprehensive information was provided by the person's school placement. A training session on the person's needs was provided by the community learning disability team. This was four days before the person moved to the service and was the first time the Cliffemount staff team had been given any information about the person's needs.

The nominated individual and the previous deputy manager only met the person on one occasion each. The school offered for Cliffemount staff to shadow their staff team to get to know the person prior to them moving but this opportunity was not taken.

This meant the Cliffemount staff did not have time to understand the person's needs and didn't have the training required to support them safely.

We found the service was working within the principles of the Mental Capacity Act (2005). Applications for Deprivation of Liberty Safeguards (DoLS) were appropriately made. Staff offered people day to day choices about their care and support.

All required checks with the disclosure and barring service (DBS) were made when recruiting staff and two references were obtained.

People were registered with a local GP and appointments were made to medical professionals when required. People were involved in planning their meals and all their nutritional needs were being met.

The two people living at the service had a full week of activities within the local community planned. They enjoyed being able to go swimming and do voluntary work.

The home was clean and furnished to a high specification, with a Jacuzzi style bath available for people to use. Regular checks were made of the fire systems and equipment. The current gas safety check certificate was not available at the time of our inspection; we were told it had been completed by the same company that serviced the fire alarm system.

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, it 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There had been insufficient staff on duty at night when a new person moved to the service.

Antecedent – behaviour – consequence (ABC) forms were completed following an incident. However these were not analysed to look for patterns or potential triggers to reduce the likelihood of a re-occurrence.

Detailed risk assessments and behavioural management plans were in place providing guidance for staff to follow.

Controlled drugs were not recorded in a separate log as required by law.

Is the service effective?

Inadequate

The service was not effective.

Training in behaviour management and restrictive intervention had not been facilitated by an accredited person and the staff had not completed the full course.

The contract for on-line staff training had lapsed. Staff had either not completed or not had workbooks assessed for mandatory courses. Training certificates in staff personnel files could not be verified. Staff did not have the training or experience to support one person who abused alcohol.

The service was working within the principles of the Mental Capacity Act.

People's health and nutritional needs were being met.

Is the service caring?

Good

The service was caring.

Staff knew people's needs well and we saw positive interactions during our inspection.

People's care files included easy read sections so the person could be involved in agreeing their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff had not received enough information, training or had an opportunity to shadow experienced staff for a new person moving to the service who had complex and challenging needs to ensure there was a smooth transition to the service.

Clear care plans and goals were in place for people. These had been completed with input from the learning disability team and had been reviewed.

A full timetable of activities within the community was in place for each person.

Is the service well-led?

Inadequate

The service was not well led.

The service had not made notifications to the Care Quality Commission (CQC) as required by the terms of their registration.

The nominated individual had tried to falsify training records. The veracity of statements taken by the nominated individual following an allegation were in doubt.

Quality assurance systems were not regularly completed. The admissions procedure for a new person moving to the service was not robust which meant the people living at the service and staff were placed at risk.

The staff enjoyed working at the service and said the nominated individual was visible within the home.

Cliffemount Community Care

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 27 January 2017. The first day of the inspection was unannounced. The inspection team consisted of one inspector for both days of the inspection.

We did not ask the provider completed a Provider Information Return (PIR) because we had been notified of a serious safeguarding allegation by the local authority and so we had brought this inspection forward. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted three local authority social service teams who have recently or currently commissioned placements at the service and the community learning disability team. Two social service teams and the community learning disability team raised some concerns about the service provided at Cliffemount. These are included in the main body of this report.

We spoke with two people who used the service, the chief executive who was also the nominated individual and acting manager for the service, the new deputy manager (who had been in post for three weeks at the time of our inspection), a relative and three care staff. A Nominated Individual is a person employed as a director, manager or secretary of an organisation with responsibility for supervising the management of the regulated activity.

During the inspection we observed interactions between staff and people who used the service and looked at records relating to the service. This included three people's care records, three staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, quality assurance audits and policies and procedures. Due to the limited verbal communication of some of the people living at the service, and the nature of their learning disability, they responded to the questions asked with a "yes" or "no" answer or by gesture.

The previous inspection took place in May 2016 and the service was rated as Good overall.

Requires Improvement

Is the service safe?

Our findings

The two people we spoke with said they felt safe living at the service. One person clearly indicated through a thumbs up gesture, that they felt safe. The relative we spoke with said their loved one was safe living at the service. They commented, "When [name] comes to our house he will indicate he wants to return by getting his shoes out. That shows he is happy and safe here."

We looked at the risk assessments in place for three people. We saw these had been reviewed and were comprehensive. They included personal care and daily living tasks and accessing activities in the community. Behavioural support plans were in place if required. These provided guidelines for staff to manage potential behaviours, for example by using distraction techniques or, if necessary, agreed physical restraint. These were detailed for the two people who had lived at the service for several years and the staff new them well. The relative told us, "Staff recognise when [name] is getting anxious and are able to support him well to de-escalate the situation. [Name] can now come to our house to visit and we can go out together."

The rota showed that there were sufficient staff on duty to meet people's needs during the day. There were three staff on duty between 8am and 8pm. There was then one staff on duty until 10pm who then undertook the sleep-in duty. However the staffing in the evening was the same when the person who lived at the service for three weeks had been there. This meant there was only one staff available after 8pm. The behavioural management plans in place for this person clearly stated that two staff were required to support them when they were agitated as they may 'target' one staff member. Having two staff on duty would allow the second staff member to support them and implement the distraction techniques identified in the plan. This was not possible when only one staff member was on duty.

For example we saw the person had some disturbed nights sleep and woke the sleep-in staff up. The rotas showed instances when the care worker had a disturbed night they also then had to work the next day. The Care Quality Commission (CQC) received whistle blowing information stating that sleep-in staff were tired as a consequence of being woken up during the night and having to work the next day, which increased the risk of incidents occurring. We spoke with the nominated individual before the inspection who told us there was a sleep-in staff and a waking night staff on duty at the service. A local authority social worker told us the nominated individual had also informed them when arranging for the new person to move to the service that there was a sleep-in staff and a waking night staff on duty. This was confirmed in the minutes from a planning meeting held prior to the person moving to the service. (However the person's social service assessment stated a sleep-in only was required.) At the inspection the nominated individual told us waking night staff were brought in if the person had been agitated during the day. However the rota's we saw did not confirm this, highlighting one sleep-in staff only. Staff we spoke with also told us there was only a sleep-in staff on duty at the service. One member of staff said, "If [name] returns (to live at the service) we will need two staff at night."

On one occasion the person woke the sleep-in staff in an agitated mood. As they were working alone this resulted in the staff member locking themselves into the quiet lounge area and waiting for two hours for the

day staff to arrive to de-escalate the situation. The behavioural management plan stated that if the person was 'targeting' a particular member of staff they were to withdraw and another staff member would support the person. However this was not possible as no other staff were on duty at the time of the incident. This meant the risks to the health and wellbeing of the person who moved to the service and staff were not safely managed due to insufficient staff being on duty.

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

We saw an antecedent – behaviour – consequence (ABC) form was completed following an incident. These detailed what had taken place before the behaviour occurred, what the behaviour was and what happened after the behaviour had finished. The aim of using an ABC form is to better understand what the behaviour is communicating to staff. The forms were detailed and in some cases included information from the whole day's events. However we did not see any evidence that the ABC forms were reviewed by the nominated individual to establish any patterns or learning form the incidents. Incident forms that would be used for this purpose were not in place. This meant the nominated individual and staff team were not able to identify potential triggers to the behaviour with the aim of reducing the likelihood of a re-occurrence.

This was a breach of Regulation 17 (1) with reference to 2(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection we looked at whether medicines were being administered, stored and disposed of safely. We saw the current months medicine administration records (MAR) were fully completed. Previous MAR were not kept at the home, but were stored at the company's head office in Keighley. We spoke with the new deputy manager and nominated individual about this as records may be required for review by the GP, psychiatrist or local authority social worker and so should be available when required.

We did see one MAR from November 2016 for one person who used the service that had been put into their personal care file. This showed that one tablet prescribed to be taken twice a day had only been signed as administered by staff once a day for the whole 28 days the MAR sheet covered. The current MAR sheet showed the medicine was still prescribed to be given twice a day. The nominated individual told us the GP had stopped the second dose as a trial for one month, however this had then been re-instated. We saw no record of this on the MAR sheet or in the person's care file as records of GP visits prior to December 2016 had been taken to head office. This meant it was not possible to evidence that the medicine had been administered as prescribed.

We saw guidelines were in place for staff as to when any 'as required' medicines should be administered. These included the signs to look for if people were unable to verbally communicate with the staff.

Staff told us they had been trained in the administration of medicines as part of their induction at the service. We saw a record of an observation of staff administering medicines was in the staff personnel files. We observed staff administering one person's medicines and this was done safely.

We looked at how controlled drugs were managed by the service. These are drugs which by their nature require special storage and recording. The controlled drugs were stored appropriately. However we found they were not recorded in a separate log, signed by two staff when they were administered as required by law. This meant there was not a record of the total number of controlled drugs stored at the service. The controlled drugs were signed when administered on the MAR chart only.

This was a breach of Regulation 12 (1) with reference to 2(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in May 2016 we found improvements were required in the recruitment records for staff. At this inspection we looked at three personnel files. We found completed application forms were in place and two references had been obtained. There was no record of people's proof of identity in the file. The nominated individual provided a list of reference numbers for peoples' Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure staff are suitable to work with vulnerable people. The new deputy manager confirmed they had completed a DBS check before starting work at the service. Proof of identity has to be provided when making a DBS application, however a copy should be held in people's personnel file.

Staff told us they had received training in safeguarding vulnerable adults and would report any concerns to the nominated individual.

We saw that the property was well maintained, clean and personalised. We saw Personal Emergency Evacuation Plans (PEEPS) had been written for each person. The PEEPS gave guidelines on how a person would react in the event of an emergency and what support they would need to evacuate the building. We saw fire drills had been completed every six months and a pictorial evacuation plan was in place which had been drawn with input from the people who used the service.

Weekly checks of the fire alarm system and monthly checks of the fire fighting equipment were completed. Regular servicing of the fire alarm, fire extinguishers and emergency lighting had been carried out according to the manufacturer's instructions. A portable appliance test (PAT) had been completed to ensure electrical items were safe to use. However the gas safety check certificate we saw was dated 2011. The nominated individual told us the gas checks were completed by the same company who serviced the fire alarms, but no certificate of proof of this was seen by the inspector.

Inadequate

Is the service effective?

Our findings

The statement of purpose for Cliffemount Community Care states that they are able to support people 'with a learning disability and / or mental health needs who may present with complex and challenging learning and behavioural needs.'

We looked at the training staff received in order to carry out their roles. Care plans stated that staff were fully trained in the use of 'Crisis Prevention Intervention' (CPI). This is a behaviour management and restrictive intervention training system used when people, for whatever reason, present with challenging behaviour. Staff said they had received CPI training from the nominated individual on the use of restraint techniques. This training was for a period of 'three or four hours.'
A local authority social worker told us the nominated individual had also informed them when arranging for the new person to move to the service that staff had been trained in the use of CPI techniques. This was confirmed in the minutes from a planning meeting held prior to the person moving to the service.

However we established that the physical intervention training used had been called Timian training. We contacted Timian training and were told the nominated individual's accreditation as a trainer for the use of Timian physical restraint training had expired in September 2015. We were also advised that the course should take two and a half or three days to complete. This meant the nominated individual was not up to date in their training to facilitate the Timian behaviour management training and the training they had provided for the staff team was not the full Timian course. Therefore staff were not sufficiently trained to follow the behavioural management plans in place. This was particularly relevant for the new person who moved to the service, who had a history of incidents that required physical intervention from staff. One staff said, "We had a few minutes training on the (restraint) holds to use for [name of person who moved to service]"

This was a breach of breach of Regulation 13 (4) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in the staff personal files certificates for key training; for example health and safety, fire training, food hygiene and infection control. The certificates were in the name of Cliffemount Community Care and not a recognised training provider. However we also saw that staff had been provided with on-line training from a recognised training provider. One staff member said, "I had an in-house induction and introduction to the service users. I was given booklets to complete on line." The new deputy manager told us the contract with the training provider had lapsed and none of the work books completed by staff had been assessed by the training provider. The staff had not completed all the workbooks they had been given. Therefore the staff had not been fully trained as their knowledge had not been checked as required by the training provider and not all booklets had been completed.

The new deputy manager said he was giving staff a booklet each week to complete. We were shown an invoice for the training provider showing Cliffemount Community Care had renewed their access to the training provider's on-line courses. The nominated individual told us the workbooks that had not been

assessed were more specialist courses such as alcohol misuse and were not the mandatory training required by all staff. However one of the people living at the home abused alcohol and required support to manage their drinking of alcohol. The staff had not completed training in this area to be able to support them effectively. A social worker we spoke with said, "The staff have not got the skills for a specialist service."

We saw from the records that staff had found several bottles of spirits in the person's room, some of which were still full. An agreement was in place that they would not bring alcohol into the house. An incident had occurred the week before our inspection where the person had drunk a quarter bottle of spirits outside of the home when staff had reminded them of their agreement that alcohol could not be brought inside the home. This resulted in the person becoming very intoxicated and they required hospital treatment. We were told this was the first time they had drunk the spirits quickly outside the property. The deputy manager told us that the staff had not had the knowledge to support someone with an alcohol problem and thought that the person had been drinking regularly in their room without the staff being aware. Therefore when challenged on this occasion they drank the full quarter of a bottle rather than give it to staff.

We saw a new agreement was in place whereby they would not bring alcohol into the house and if they consumed more than two pints of beer when out with staff, the staff would not be able to continue to support them on safety grounds. We spoke with the person and they said they had agreed to this.

We were told by the deputy manager and staff that they were completing the care certificate on line. The care certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

This meant the staff had not received the training they required to undertake their roles and meet the needs of people who may have 'complex and challenging learning and behavioural needs.' This was a breach of breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the previous deputy manager had completed staff supervisions every three months. These included reminders for staff to complete the training workbooks mentioned above and a discussion about the support people who used the service required. The new deputy manager was planning the dates for staff supervisions for the coming months at the time of our inspection.

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We saw that a DoLS had been authorised for one person and had been re-applied for when it had lapsed after one year. The other person supported at the time of our inspection had capacity to make their own decisions about their care and support.

This meant the service was working within the principles of the MCA.

People were encouraged to make their own day to day choices about what they wore, what they ate and the activities they were involved in. Where required people had a communication passport which gave detailed information about what they were trying to communicate through their actions. This helped staff to support people to be involved in and make day to day decisions about their care.

However one person had self-administered their own medication. Staff had found that when the person had had a drink of alcohol they did not take their medicines. The person locked their bedroom door and would not give staff access to their room. In response a new care plan had been written and staff had started to administer the person's medicines again. The new deputy manager was looking for a less restrictive option with staff observing the person take their own medicines to promote their independence. They were also arranging for the bedroom door lock to be changed so staff would be able to gain access to the room in an emergency, whilst still enabling the person to lock their door.

We saw people were registered with a local GP and were supported to attend medical appointments when required. Each person had a health action plan in place. This provided staff with information about the person's health needs. There was also a hospital passport in place. This provided hospital staff brief details of people's needs and how they communicated in case they had to be admitted to hospital. We saw the staff had responded quickly and appropriately when one person had had a seizure.

One person had a care plan in place for the support they required when attending medical appointments, either with staff or with their family, as they could become anxious about the medical appointment. However this did not mention that 'as required' medication may be needed to reduce the person's anxiety. We saw from the daily logs that they had recently attended the dentist supported by their family and 'as required' medication had been taken with them so it was available if required. On this occasion it was not needed. The care plan should specify that the 'as required' medication should be available when going to medical appointments.

One person had been supported to obtain a referral to an alcohol support service so they could receive professional support with their alcohol issues.

We saw people were involved in planning a weekly menu. People were encouraged to make their own drinks and snacks. People were weighed monthly and there were no concerns about people's weight at the time of our inspection.

The home was large and spacious with Jacuzzi baths and two large lounges and one smaller quiet lounge. The home was well decorated and people had personalised their own rooms. The property was homely and well appointed.

Good

Is the service caring?

Our findings

At the time of our inspection there were two people living at the service. On both days of our inspection people were busy with activities and were out of the house. Therefore our observations of the interactions between staff and the people who lived at Cliffemount were limited.

Both the people we spoke with were positive about the staff team who supported them. One said, "The staff are good, they encourage me and I can ask them for support when I need it." The relative we spoke with said the staff knew their loved one very well and were able to recognise and respond to their needs. They said, "We couldn't be happier."

A social worker we spoke with said, "The staff have the knowledge to support [name] as they have known them a long time."

During the inspection we saw kind and respectful interactions between people who used the service and the staff team. People were comfortable to ask either verbally, through gestures (for example getting the keys for the car to indicate they wanted to go out) or by writing words down on a piece of paper for support or to go out. Staff responded appropriately to these requests.

People's care files contained information about people's likes, dislikes, hobbies and interests. This meant staff were able to form meaningful relationships with the people they supported.

We saw one person's care files contained some easy read sections which enabled the person to be more involved in developing and agreeing their care plans. A visual evacuation plan for the property had been made by the people who used the service by drawing the escape routes onto a plan of the building. This showed people were involved in planning their care and support.

We saw care plans were in place to inform staff of the tasks people were able to complete for themselves. These including people preparing their own breakfast and having a routine for their personal care in a morning which they now completed independently. This also showed how staff supported people to maintain their privacy and dignity when undertaking personal care tasks.

We saw people's care files were stored in a locked cupboard or in the office. This helped to ensure that the confidentiality of people who used the service was maintained.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care plans in place for both people currently living at the service. We found the care plans to be detailed and provided guidance for staff on the support people required, including what people could do for themselves.

People had clear person centred goals in place. For one person a review of the person's original goals set in 2012 when they joined the service had been completed in December 2016. This noted the progress they had made towards these goals and identified new goals they wanted to work towards. For example it was noted the person was now able to make their own breakfast of toast and cereal and now wanted to learn how to cook some simple meals. There was also a document called 'What you need to know to support me.' This gave guidelines for staff when supporting the person. A communication passport was also in place, developed with input from the Speech and Language Team (SALT). This gave clear details of what the person meant when they said or did certain known things. For example if the person was asking a repetitive question it meant they were seeking attention and staff were to respond once and then use a sign for 'finished'. Guidelines were also in place for distracting the person if they were becoming anxious.

One person's goals had been reviewed with them in June 2016 and included becoming more independent in their daily living skills as they wanted to eventually move into their own flat.

We noted most of the care plans and risk assessments had been written in 2012 and subsequently reviewed and added to. Due to the number of changes since joining the service the care plans would benefit from being rewritten onto a new care plan document.

We saw review meetings had been held with the two people's social worker to agree the goals and support in place to achieve them.

Both people living at the service at the time of our inspection had a full week of planned activities. These included swimming, visiting the airport, guitar lessons and voluntary work. A member of the learning disability team told us they had had a lot of input with Cliffemount Community Care in working with the staff team to improve the communication and activities for one person who used the service. They said when the previous deputy manager had started working at the service they had driven the improvements in the support for this person and they were now a lot more active than before. They said they had to make a lot of re-visits to the service to ensure the staff were using the techniques they had been shown. This meant the staff were now able to communicate better with the person and they now had a full week of activities they enjoyed doing. As a result the person was now more settled and there had been fewer incidents of behaviours that may challenge staff.

We also looked at the care plans for the person who had moved to the service for a period of three weeks. The plans included a lot of information gathered from the person's school placement, as well as social service assessments. These included information about the person's communication needs, the meaning of certain phrases or actions and de-escalation strategies if the person was becoming anxious. A document

guiding staff what to do if the person's behaviours escalate was also available.

We noted the transition period for the person was short, being three weeks from Cliffemount being asked if they could provide a service for the person to them moving in. During this period the nominated individual met the person once at their school setting. The previous deputy manager also visited the school to gain some insight as to the person's support needs and challenging behaviours. However we were told by the social worker involved that other opportunities to visit the school and shadow staff supporting the person were not taken. The school had offered for the staff team to visit the school to try to get to know the person a little before they moved to Cliffemount. This was not done.

The community learning disability team undertook an a half day training session with the staff team to inform them of the person's needs and strategies to be used when supporting them four days before they moved to the service. We were told this was the first time the staff had been provided with any information about the new person moving to the service, despite information being available prior to this training session.

A behaviour support plan had been written (dated 13/12/16) and viewed by the community learning disability team for comment. The nominated individual told us the community learning disability team had not signed this document off so the staff were unable to use any restraint if the person became aggressive. A community learning disability nurse told us they do not sign off behaviour support plans as they are not trained in restraint techniques. They will review the plan and make comments for changes to the plan. The Cliffemount Community Care policy for restrictive physical intervention states there should be a record of techniques to be used and a breakdown of the training staff have to complete before using any physical restraint. As previously noted in this report the nominated individual had said the staff team were fully trained in distraction and restraint techniques. However this was not the case. Specialist training for staff in supporting people with complex needs was not in place. The record of techniques to be used was incorporated in the behaviour support plan. One staff said, "I had training from [nominated individual] for about 45 minutes on how to hold [new person joining the service]." This was confirmed by the previous deputy manager.

The nominated individual said they felt pressured by social services into accepting to support the person. The social worker and community learning disability team said they asked if the service was able to meet the needs of the person and were told that the service could. Minutes from a planning meeting held on the 14 December 2016 show the nominated individual stating staff were trained to meet the person's needs.

An incident occurred on the 8 January 2017. We found that staff had not followed the guidance for avoiding and de-escalating incidents and this resulted in a serious incident taking place. The person was given the keys to the car owned by the service so they could clean it. They became angry when the keys were later taken from them as they wanted to drive the car. One staff said, "It went too far when we were washing the car; we took the keys from [name] and they got agitated." The new deputy manager said, "Why give [name] the car keys? That day could have been avoided."

We found that the staff team had not had sufficient information or the chance to shadow, and learn from staff at the school who knew the person well. Staff were not sufficiently aware of the guidelines in the risk assessments to distract the person when required. This potentially resulted in incidents occurring which could cause injury or harm to the person and others. These could have been reduced in their intensity.

The procedure for ensuring staff were fully aware of people's needs prior to them moving to the service was not robust enough. The nominated individual had agreed to support a person their staff team were not

experienced or suitably trained to be able to meet their complex needs.

We found this to be a breach of Regulation 12 (1) with reference to 2(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The registered manager for the service had been off work since June 2015. At this inspection we were told they would not be returning to work. The nominated individual was the acting manager. A deputy manager had been appointed in May 2016, but had recently left the service. A new deputy manager had been appointed. The nominated individual told us the new deputy manager was going to be the registered manager for the service.

At our last inspection in May 2016 we advised the nominated individual that they needed to notify the Care Quality Commission (CQC) of any absence of the registered manager of more than 28 days. This still had not been done at the time of this inspection.

The failure to notify the CQC appropriately was a breach of Regulation 14 (1) of the Care Quality Commission (Registration) Regulations 2009.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC. Before the inspection we found CQC had not received any notifications from the service since March 2015.

We were aware through the local authority safeguarding team of a number of allegations made against staff and incidents that had taken place at the service. The allegations were not substantiated. In one incident two staff were injured by a person who used the service and the police were called to assist. These allegations and incidents should have been notified to the CQC. We also saw ABC forms had been completed which involved two people who used the service. These should also be notified to the CQC as potential safeguarding issues. The Cliffemount Community Care policy stated that staff should inform the nominated individual who would then make any notifications required. The nominated individual had not done this.

The failure to notify the CQC appropriately was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

The nominated individual emailed us after the inspection to inform us that their accreditation for being a Timian breakaway and restraint trainer had lapsed due to an oversight, stating he had thought it was valid for three years and was due to run out in February 2017. The accreditation was actually only valid for one year. However we had already spoken with Timian training who had told us the accreditation ran out in September 2015. This meant that it was not possible for the accreditation to have run out in February 2017, even with an oversight by the nominated individual thinking it was valid for two years longer than it actually was. Staff also told us they received Timian training from the registered manager for 'a few hours'. Timian training told us the course was usually run over three days, and if longer days were used possibly two and a half days. Therefore the nominated individual was not using the full course as set out by Timian and as detailed in Cliffemount Community Care's restrictive physical intervention policy. We saw in one staff members file a certificate to state they had completed the Timian training, however they had not been given

the full course by an accredited trainer. No Cliffemount Community Care staff had been registered with Timian training as having completed the training.

In addition the nominated individual said the mandatory courses had been completed with Leeds City College. After the inspection we contacted Leeds City College who said the named person on the Cliffemount certificates was not known to them and they did not undertake all the short courses specified on the certificates. The certificates did not have the Leeds City College logo on to denote they were an official Leeds City College course.

This meant the nominated individual had tried to falsify the training records.

The nominated individual told the inspector prior to the inspection there was a sleep-in staff and waking night staff on duty at the home. During the inspection they said there was a waking night staff on duty if the new person had been agitated during the day. Staff told us there was only a sleep-in staff on duty from 8pm each night. The rotas we saw showed a sleep-in staff was due to work each night. There was no note on the rota's that any waking nights had been worked or had been scheduled to work. Following an allegation against staff from the 29 December 2016 the nominated individual took statements from the staff on duty at the time. The previous deputy also took a statement form one of the staff members. Their two statements differed. The statement taken by the nominated individual said there was a waking night staff who supported the person whilst the sleep-in staff stayed in the sleep-in room. The statement taken by the deputy manager stated the sleep-in staff was on their own, went to the sleep-in room to keep themselves safe and waited for the day staff to arrive to support the person. Two staff we spoke with confirmed to us that the staff member was working alone and went to the sleep-in room and waited for the day staff to arrive.

We also saw a series of text messages between the previous deputy manager and the nominated individual. These clearly showed the previous deputy manager stating the current night time staff arrangements of a sleep-in were not sufficient.

This meant there were concerns over the veracity of the statements taken by the nominated individual when investigating the allegations made.

We found the provider had not fulfilled their statutory responsibilities and did not demonstrate they had the qualifications, competence, skills and experience which were necessary for their position.
This was a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the quality assurance systems at the service and saw an audit file was in place. This contained weekly premises audits completed by the previous manager. However we saw the same issues were being reported. For example it had been noted that the small en-suite bathroom required a new toilet seat and new window braces in September 2016 and these were still outstanding in December 2016. This room was not in use during this period.

We saw a medicines audit had been completed in January 2016 but no record of any other medicines audits were seen. The new deputy manager said they checked the medicine administration record (MAR) daily to check medicines had been administered as prescribed. As mentioned previously in this report we did not see any analysis of incidents to look for patterns or potential triggers so staff could learn from the incidents and improve the care and support they provided.

We saw a manager's daily log sheet was in place. This was a record for checks including for cleaning, fridge temperatures, look at new ABC charts and that medicines had been administered However this had not been used. The new deputy manager was now using this check sheet each day they were on shift and was planning to delegate the task when they were off.

Cliffemount Community Care literature states they 'provide residential care services for men and women with a learning disability and / or mental health needs who may present with complex and challenging learning and behavioural needs.' The service's statement of purpose said that they support people 'whose needs are complex in terms of support, enablement, living skills and community participation.' People may have a learning disability, physical disability, autism or mental health needs. The statement of purpose was out of date as it focused on supporting people in their own homes, which Cliffemount Community Care no longer offer.

We found the staff team did not have the training or experience to support people with complex needs, especially new people moving to the service. The two people currently living at the service were well known to staff and were safely supported by the staff at the service. However, one person did not receive day to day support with their alcohol issues as staff had not been suitably trained for this and therefore had little insight into meeting their needs in this area. They had been referred to external alcohol services; however support within the home was also required to meet their needs in this area.

The nominated individual had agreed, at short notice, to support a person with complex and challenging needs. The staff did not receive relevant information about the person's needs and behaviours quickly enough, have the opportunity to get to know the person by shadowing experienced staff at the person's school setting and did not have the training or experience to meet their needs. This placed the person who moved to the service, the other people living at the property and the staff at risk.

This was a breach of Regulation 17 (1) with reference to 2(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with said that they enjoyed working at the service and supporting people with the wide range of activities they did. They said the previous deputy manager was very supportive and the nominated individual was visible within the service, working some shifts and visiting at least once per week.

Staff said they held staff meetings when required; however they were a small staff team and were able to discuss any issues or items regularly with the deputy manager during the daily handovers or during their shift.

We saw the service had a set of policies and procedures in place. They were not dated so it was not possible to verify that they had been reviewed and were the latest version. The new deputy manager was in the process of going through the policies and ensuring they were all up to date at the time of our inspection.

We found multiple breaches of the Health and Social Care Act 2008 during this inspection. These included the recording of controlled drugs, staff training and ensuring staff had the qualifications and experience to meet the needs of a new person moving to the service. There had been insufficient on duty over night to meet the needs of the new person. The nominated individual had falsified training records and information given to the inspector with regard to overnight staffing levels and statements made following an allegation against a staff member. The nominated individual had failed to notify the CQC of events as required by the terms of their registration.