Mental Health Care (U.K) Limited

Acrefield House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 August and 19 September 2018. The first day of the inspection was unannounced.

Acrefield House is a 'care home'. People in care homes receive accommodation and nursing 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. The care home is a large Victorian style building over three floors in a residential location. The home provides care and support to people who have a learning disability, autism or a brain injury. The home is registered to provide care and accommodation for up to 12 people. At the time of our inspection nine people were living at the home.

The home is required to have a registered manager. Since our previous inspection there was a new manager in place. The new manager was in the process of applying to become registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our previous inspection in November 2017 we had found breaches of regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for the service was 'requires improvement'. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions; 'Is the service safe?' 'Is the service effective? 'Is the service caring? and 'Is the service well-led?' To at least a rating of good.

At this inspection we found that there had not been sustained improvements to the quality of the service provided for people and the majority of the actions we were told the provider would take had not been completed. Although the service was no longer in breach of Regulation 10, there was a breach of Regulation 9 and there was a continued breach of Regulation 17 for the third inspection in a row. This is because the provider had not ensured that people's care and support always met their needs and reflected their preferences; and the provider had not taken adequate steps to assess and improve the quality of the service provided for people. Therefore, arrangements made by the provider for leadership of the service have not been adequate.

This service was not provided in line with the values that underpin the Registering the Right Support and other best practice guidance. The values underpinning Registering the Right Support include choice, promotion of independence and inclusion; to help enable people with learning disabilities and autism using the service to live as ordinary a life as any citizen.

Whilst people were cared for and kept safe; we saw little evidence that showed choice, promotion of independence and meaningful inclusion were integral to people's support. Many aspects of people's

support appeared to be aimless, it did not regularly promote people having enriching and everyday life experiences.

We have had some concerns with the quality of the service provided for people since our last inspection. One staff member raised concerns about bullying within the home; their concern was then followed by other staff members raising concerns. Also, we learnt from the local authority that historically staff at the home were not following the correct procedures in recording and reporting allegations that people at the home had made. When the manager became aware of these concerns they responded, took appropriate action and were open about these concerns. However, this is the third inspection where we have concerns about the culture and leadership within the home. We are meeting with the provider to address these concerns and we will inspect the home within six months to ensure that action has been taken.

Staff all had received training in safeguarding vulnerable adults with an upcoming training refresher booked for staff. Safeguarding and whistle blowing had been agenda items at recent team meetings, which ensured that staff knew how to raise an alert.

The administration of medication at the home was safe. The medication was stored securely in a well-equipped medication room that was temperature controlled. Each person had detailed information recorded about their medication which helped staff ensure they administered it accurately.

The environment of the building was safe, it was clean and well maintained. We saw that environmental health and safety audits had been completed on the equipment and services at the home.

The service was working within the principles of the MCA. We saw that appropriate capacity assessments were in people's files. These assessments showed an understanding of the person's right to be involved in the decision-making process as much as possible and in regard to the specific decision being made, this had helped staff to support people with specific decisions effectively.

People told us that they liked the food provided at the home. The food looked and smelt tasty and appetising, in a home cooking style with a varied menu. There had been an improvement to the breakfast experience with a new breakfast bar enabling people to choose and help themselves to breakfast. Staff told us this had been a positive change and some people were much more involved in the preparation of their food.

People's rooms were personalised and decorated the way they wanted them. There had been improvements since out last inspection to bathrooms and the kitchen. The home made use of assistive technology to support people to have greater independence around the home whilst remaining safe.

People's support plans contained information on how to support the person with communicating their needs and wishes. Also, information in relation to their medication and health care had been reviewed. This had led to some positive changes for people.

Staff members told us that they felt the new manager was positive and approachable. They told us that the team changes had been positive in that people no longer work in set teams and work alongside all of their colleagues. When the manager had become aware of any complaints or information of concern we saw that they had investigated and responded to these.

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

The service did not hold information about the suitability of all staff members.

Incidents were not always effectively responded to.

Staff members had received training in safeguarding vulnerable adults.

There were sufficient numbers of staff supporting people and medication was administered safely.

The homes environment was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The training and ongoing support provided to staff had not always been effective.

The service operated within the principles of the Mental Capacity Act (2005).

People received support with their healthcare.

People told us they liked the food provided.

Is the service caring?

Requires Improvement

The service was not always caring.

Sufficient attention was not given to always treating people with dignity and respect. Actions the provider told us they would take to improve this had not happened.

People at the home told us they thought the staff were nice to them.

There were regular meetings for people living at the home to

express their views and information was available in an accessible format for people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's support did not always meet their needs and reflect their preferences.

Support staff did not always follow the guidelines in people's support plans.

There was an overreliance on staff who were not familiar with people's support needs.

When the manager had become aware of any complaints or information of concern we saw that they had investigated and responded to these.

Is the service well-led?

Inadequate

The service was not well-led.

Some of the improvements noted in our previous inspection had not been maintained. Also, most actions the provider told us they would take following our last inspection had not happened.

Arrangements made by the provider for leadership of the service had not been adequate.

Other events had happened since our last inspection which had raised concerns about the culture within the home.

Staff members told us that they felt the new manager was positive and approachable.

Acrefield House

Detailed findings

Background to this inspection

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

We brought this inspection forward because of information sharing from the local authority. These were concerns raised by a whistle blower about the way some people were treated and a concern with the way safeguarding information had been dealt with at the home. We also inspected to check if improvements had been made in line with the provider's action plan which had been provided to the CQC.

This inspection took place on 30 August and 19 September 2018, the first day was unannounced.

The inspection was completed by an adult social care inspector and an assistant adult social care inspector. Before our inspection we obtained the view of the service from the local authority quality assurance. We checked our system and looked at the information we had received from the service since our last inspection; including statutory notifications from the service. We looked at the care plans for five people and other records relating to the management of the home.

During our inspection we spoke with five people who lived at the home. We spoke with nine members of staff including two directors, a quality manager, the home manager and five people who provided care and support to people. We also spoke with one visitor.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person told us that they like the home and liked the staff at the home. Another person said, "I like it here now."

There had been no recruitment of new care staff since our previous inspection. The service was using agency staff to supplement the staff team. We asked the manager what information the service held about these agency staff members. They initially told us they were not sure if the service held staff profiles, giving them key information about the agency staff members. During the inspection we became aware that no staff profiles were held.

This meant that the service held no information about these staff members and was totally reliant on the judgement of a third-party agency to ensure that relevant safe recruitment checks had been carried out. However, it is the providers responsibility to assure themselves that people working in their service are fit and proper persons to support vulnerable adults.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the provider had not monitored the safety of all staff members being used to provide support to people.

Since our last visit the provider had redesigned the recruitment selection process for staff with a stronger focus on the applicant's values during the recruitment process. This was in place but had not yet been used.

The improvement in the response to incidents and accidents had not been sustained. At our inspection in November 2017 we had noted that the response to incidents at the service had improved. There had been regular incident review meetings involving staff where they explored potential medical, social and environmental causes for incidents. However, at this inspection we saw that these incident review meetings had stopped; the last one was in December 2017. One senior staff member told us that they, "Haven't had them because there have not been any incidents."

However this was not the case. We looked at incidents and saw that at times the information regarding incidents was not complete. Not all incidents that were written on people's daily care notes were on the incident recording system and there was not always information of what was being done immediately after a serious incident to help prevent further occurrences. Information about physical or verbal intervention by staff was sometimes missing. There was some evidence that staff learnt from incidents, but the method in place for doing so was not being used. The debriefing of staff did not always happen, with many incidents noting that the staff member was not available for a debrief, yet there was no note of this being followed up. One staff member told us that they used to analyse incidents with the previous manager but this was now, "On the back burner."

Although people had risk assessments in their files these had not always benefitted from a thorough reviewing process after incidents had happened at the home.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the provider had not used the recording of incidents to monitor the safety of the service being provided for people.

Staff members we spoke to told us they had received safeguarding training and told us that they were confident in following relevant procedures that would keep people safe. Staff members knew about the ways they could raise concerns outside of the organisation if they thought that this was appropriate.

We saw that staff all had received training in safeguarding vulnerable adults with an upcoming training refresher booked for staff. Safeguarding and whistle blowing had been agenda items at recent team meetings, which ensured that staff knew how to raise an alert. Staff had access to and were able to show us the service's safeguarding and whistle blowing policies. We saw that the service conducted audits of safeguarding alerts, with the last one being in July 2018 and the manager had made appropriate safeguarding referrals.

The planned numbers of staff at the home had been reduced since our last inspection. The manager told us that this was now more in line with people's assessed support needs. We saw that there were enough staff available to meet people's support needs and the manager told us that the staffing levels enabled each person to have a block of one to one support to do things they chose.

We also saw that if people stayed in their room for any length of time they had a call bell so they could get help from staff if needed. One person told us, "I press the bell when I need something. They come quite quickly."

We saw that the administration of medication at the home was safe. The medication was stored securely in a well-equipped medication room that was temperature controlled. Each person had detailed information recorded about their medication which helped staff ensure they administered it accurately. There were also daily checks of medication stocks which would highlight any mistakes if they had happened. The sample of records and stocks that we checked were all correct.

We saw that there had been regular audits of the administration of medication at the home. The audit included looking at the use of as and when required medication (PRN) to help ensure that this was being used effectively. Records showed that this medication was only used when necessary and there were no significant patters of usage. Any medication errors were recorded as an incident and investigated.

We saw that the environment of the building was safe, it was clean and well maintained. We saw that environmental health and safety audits had been completed on the equipment and services at the home. We also saw that equipment was in place and staff followed good infection control practices.

There was a fire risk assessment from May 2018, which included a floor plan of the building. We highlighted to the manager that there was no record of any fire drill at the home as outlined in the risk assessment. There were weekly recorded checks of the fire alarm system; along with periodic checks of the emergency lighting, smoke detectors and emergency fire door closers. We also saw that each person had an individualised personal emergency evacuation plan (PEEP) that showed how to help people safely in an emergency had been planned.

Requires Improvement

Is the service effective?

Our findings

Staff at the service told us they felt supported in their roles. Some staff told us that they had seen a lot of changes at the home and some staff said that this felt like constant change.

Team meetings took place on a regular basis and staff had supervision meetings with a senior member of staff. There was a system in place to ensure that staff received training according to the providers policies and periodic refresher of this training. We also saw that staff were trained in awareness of certain health conditions that people living at the home had.

However, the training and ongoing support provided to staff had not led to them developing skills to sustain positive changes in the support provided to people; to ensure it was in line with current good practise and the values of registering the right support. These include supporting people with learning disabilities and or autism with choice, the promotion of independence and inclusion.

When people had expressed choices and preferences, the ongoing assessment of their needs and choices had not been effective in ensuring that their support had enabled them to meet them needs and choices.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service was working within the principles of the MCA. The manager had oversight of DoLS and was able to show us who had one in place and which people a DoLS had been applied for but had not yet been granted by the relevant authority. We saw that appropriate capacity assessments were in people's files. For example, in one person's file that was an assessment of the person's capacity to consent to their care, staff managing their finances and a capacity assessment about a specific decision, before this decision was made using the best interest process. These assessments showed an understanding of the person's right to be involved in the decision-making process as much as possible and in regard to the specific decision being made, this had helped staff to support the person effectively.

We saw that people received effective support with any health conditions they had. There were detailed records of people's health support needs and information, guidance and recommendations from any healthcare visits was recorded. Staff had the information to help them monitor and assess people's health

conditions to guide them on when to seek medication assistance or advice. We also saw evidence that appropriate referrals had been made. For example, to speech and language therapists, dieticians and to medical professionals for specific health concerns.

People told us that they liked the food provided at the home. Since our previous inspection the home had employed a member of staff dedicated to providing cooked meals. We sampled some of the food made for people. The food looked and smelt tasty and appetising, in a home cooking style with a varied menu. Staff told us and we saw in feedback at team meetings it was recorded that people were eating better. Early one evening, one staff member made pancakes for supper that people seemed to enjoy.

There had been an improvement to the breakfast experience with a new breakfast bar enabling people to choose and help themselves to breakfast. Staff told us this had been a positive change. Staff told us that people were much more involved in the preparation of their food.

We saw that people's rooms were personalised and decorated the way they wanted them. There had been improvements since out last inspection to bathrooms and the kitchen.

We also saw that the home made use of assistive technology to alert staff when some people needed support and to monitor some people's safety with specific health concerns. This supported people to have greater independence around the home whilst remaining safe and having support when needed.

Requires Improvement

Is the service caring?

Our findings

During our inspection in November 2017 the service was in breach regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect.

We asked the provider to give us an action plan showing what they would do and by when to no longer be in breach of Regulation 10 and to achieve a rating of at least good in the key question 'Is the service caring?"

The majority of the actions and aims in the action plan had not been completed. For example, in the action plan from February 2018 the provider told us they would, "Introduce dignity champions to drive and motivate the staff team; using available resources / toolkits to run workshops sessions and audit the staff teams approach and understanding." We asked some staff members about this; one senior staff member told us, "No meetings happened, I think that's [dignity champions] finished now." Another staff member we spoke with told us they were a dignity champion; they told us they had not had any training in this or attended any workshops and did not know anything about any audits. We asked about any resources they had been provided with and they told us that they had only been given a list of Do's and Don'ts in the use of language.

The action plan also stated that staff would complete Skills for Care training on dignity and respect and they would, "Develop a team ethos by working together to develop a team mission statement / poster describing their values and beliefs." The manager and staff told us that none of these things had happened. We asked one staff member what the mission of the home was and they said, "I don't know."

The provider had also told us in the action plan that the new manager who started in February would be working alongside staff to guide and coach them to improve people's support. We were told that this had not happened and was due to start imminently. This is six months after the action plan was produced. Other areas of the action plain including an increase for people in community access and independence and staff training in communication and communication aids; had also not happened.

People at the home told us they thought the staff were nice to them. When we spoke with staff and observed their support of people, staff were cautious about speaking with us. Previous inspections had resulted in the home having a negative public report. We spent some time in communal areas of the home and saw that not all of the interactions were positive. Whilst staff appeared friendly with people; the atmosphere in the home was not relaxed or warm. We saw staff standing around and not always interacting with people or interacting in a way that did not appear relaxed.

We saw that one person was sitting in the lounge on an incontinence pad, it was obvious that this was the case. They were having a drink whilst watching television. Soon after they had finished a member of staff asked them, "Would you like to put you glass in the kitchen and can in the bin [name]." The staff then followed the person into the kitchen. The interaction felt authoritative and was not very dignified for the person.

We did see that some interactions that were positive and respectful. We saw staff being respectful of people's private space and knocking before they entered their room; asking permission before providing support and offering day to day choices for example at mealtimes. People's private and confidential information was respected; care plans were kept in a locked office and information on computers was password protected.

When we asked a director from the provider organisation about their observations when visiting the home, they told us; "Nobody has set out clear expectations for staff." They added that there are not appropriate and proportionate challenges of staff members by senior people at the service. Again, we were told about how they are exploring plans for this service and how things will improve in the future.

There were regular "resident's meetings" facilitated by one of the home's team leaders were people's views on matters at the home was sought. We also saw that information about the 'residents meeting' and other information about the home was in a pictorial or easy read format. There was also an independent lay person who attended the home and checked the quality of the support being provided to people and people's feedback.

Requires Improvement

Is the service responsive?

Our findings

Each person had individualised care files containing detailed information about the person and how to support them. In November 2017 we noted that there was evidence that people's care plans had been regularly reviewed and these were 'live' documents, with staff making regular updates with new information and observations.

This improvement had not continued and people were not always receiving support that reflected their needs and wishes as outlined in their care plans.

Also on this inspection we saw that the values underpinning Registering the Right Support were not shaping the way support was provided to people. These values include choice, promotion of independence and inclusion; to help enable people with learning disabilities and autism using the service to live as ordinary a life as any citizen.

For example, people were not receiving support that promoted inclusion within their community and regular participation in meaningful activities. On the first day of our inspection we saw that people were not being supported to engage in activities within the home or in their community. We saw some people wandering from room to room and others sitting in the lounge with the TV on, not actively watching the TV. When we looked at people's care records for this day they showed that three people went out from the home to local shops. One of these people later went for a drive and visited their family. Six people stayed at the home all day.

Also, people were not receiving the support they wanted as set out in their care plans. For example, in one person's care plan it stated that a good day for the person included, "Walking to the shop to get my can of coke." A bad day was, "Not going to the shop for my coke." In August it was recorded that this person went to the shop eight times. For thirteen days there is no record of them leaving the home. Their care plan also stated, "I like going to the disco twice a week." However, there is no record of the person going to the disco during August.

In another person's care plan, it stated that it was important to them to watch their favourite local football team live and have trips out; to two local places that they enjoyed going to. However, this person's care plan was not being followed. In August the person was recorded as leaving the home on two occasions; once to go to watch a football match and once to have a trip to a local place of interest. For 27 out of 29 days it was recorded that the person stayed in the home and watched television and chatted with staff members. At the most recent review of this person's care plan it had been recorded under the heading, "What is not working"; that the person said, "I don't get out enough."

When attending events in their community the details of how to support a person were not being followed. For example, when visiting a football stadium, it was recorded that it was important to the person that they stayed until the end. The plan stated, "At the end of the game I prefer to wait until the majority of the crowds have left before exiting the stadium." At the most recent visit to the stadium the person's plan had not been

followed. It was recorded by staff members that the person, "misbehaved after watching football". The person had been asked to leave the football match by care staff before the game had finished as a taxi had been booked; the taxi was then late and this led to an incident occurring that the records indicated the staff member did not have the skills or knowledge to prevent or de-escalate when happening. It also showed a lack of proactive planning so that the information in the person's care plan could be followed. During a debrief the person expressed that they were not happy having to leave the game before it was finished. The manager noted that a risk assessment will now be completed for this person visiting football games. A senior staff member we spoke with about this told us the incident was regretful and it would have been better if the person had waited; putting the onus for the trip not being successful on the person and not on them receiving the right support.

For a third person there was a record to show that their social worker had contacted the provider mid-July and had expressed concerns that the person they were involved with had only left the home four times since June and two of these times were for medical appointments. It was recorded that their social worker expressed concerns that the person was under stimulated both inside and outside of the home.

There was also further evidence that people's care plans were not being followed in the way they were supported. For example, in one person's support plan it directs staff that distraction techniques and talking about things important to the person is better than telling the person to stop doing something that may pose a risk. However, we noted in incident reports completed by staff that they were telling the person to stop what they were doing.

No new care staff had been recruited since our inspection in November 2017 despite seven staff members leaving the service. This had led to an increasing reliance on care staff provided by an agency. The agency staff were not as familiar with people and their care needs. The manager told us that they also did not have enough care staff who had driving licenses. This was having an impact on people being able to use the vehicle available. One senior staff member told us that the aim of the service is to develop people, however at times it is "more about monitoring."

We spoke with the manager about this. They told us that there was a, "Lack of positive risk taking due to a lack of confidence by staff." They described that at times the service is still responding to risk that is historical and happened many years ago with staff had "fixed" thinking about people and their support needs. The manager also told us that since the activity co-ordinator had left, "Staff haven't been motivated enough."

The manager told us that three people's care files had been reviewed. We looked at these and saw that yellow stickers had been put on the care plans asking questions and highlighting missing information. These reviews had not been completed to make sure the care plans reflected people's needs and preferences and that people were receiving appropriate support. The manager was also unable to find any records of care file audits on the organisation's electronic audit system.

For some of the people living at the home the day to day support they received did not reflect the daily choices and preferences they had made as documented in their care plans. This meant that people had limited opportunity to enjoy ordinary life experiences.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the provider had not ensured that people's day to day care and support met their needs and reflected their preferences.

Information in care plans did not always provide the most up to date information on people's care and support needs. For example, in one person's care plan there was advice from a healthcare professional that stated the person needed support from one staff member when indoors and two staff members when outside. However, in the person's care plan there was no mention of the support needed when being mobile. In a risk assessment it stated the person needed support from one staff member when inside, but there was no mention of what support was needed when outside. The manager told us that the person now used a wheelchair when out; but this has not been added to their care plan. The person was receiving appropriate support with their mobility, but this showed that care plans were not kept up to date.

Specific significant events had been organised for people that were important for them. For example, we saw that one person had been to a music concert over the summer and had been supported to celebrate their birthday with family. Also, there were arrangements in place for some people to visit the home to provide activities, such as entertainment and hand massages to help them relax.

We saw that people's plans contained information on how to support the person with communicating their needs and wishes. Some people's care plans and communication passports were written in a pictorial format if this helped the person to read them. The pictorial plan contained information on people likes, dislikes and lifestyle choices. It was person centred in that the service documented information in a format that the person could understand. We saw that the person was involved in producing the document along with staff members and the speech and language team if they were involved.

People's information in relation to their medication and health care had been reviewed. This had led to some positive changes for people. For example, one person was supported to move room onto the ground floor, which helped them to remain independent. Also, the home had prompted a review of the support provided to two people with the commissioners to work out if the home was the best place to meet the person's needs and wishes. The manager told us that this was part of a process that would be ongoing.

When the manager had become aware of any complaints or information of concern we saw that they had investigated these and had responded. Also, if necessary they had made appropriate referrals to the local authority.

Inadequate

Is the service well-led?

Our findings

There was a new manager working at the home; who had been in post for seven months, since February 2018. They had not been the manager during our previous two inspections in February and November 2017, during which we had highlighted areas of concern. The manager was in the process of registering with the CQC.

During our previous inspection in November 2017 we saw that some improvements had been made. However, the service was still in breach of Regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to give us an action plan showing what they would do and by when to no longer be in breach of Regulation and to achieve a rating of at least good.

At this inspection we saw that the majority of the actions in the plan had not been achieved. For example, we were told that people would have new person-centred care plans, that people and their families contribute to; reflecting the findings of an assessment of people's needs. This had not happened. Also, staff would receive direct coaching from the manager; the manager told us they have, "Not had the chance." And, care records would be assessed using a robust audit system.

Some of the improvements we had noted in November 2017 had not been maintained. For example, the regular incident review meetings which involved staff in exploring potential causes for incidents had stopped.

Also, during our previous inspection we noted that people were regularly going out into their community. One staff member had told us, "People do more now that they used to do." However, this had not been maintained and whilst we don't advocate any particular method of involving people in their community; the service no longer had an activity co-ordinator. The manager told us the activity co-ordinator had previously prompted people going out more into their community.

Arrangements made by the provider for leadership of the service had not been adequate. The service has had three managers and other interim managers in the time period of our last three inspections. The manager of the home told us that they had not received an adequate induction by the provider into the role and felt like they had been, "Left to float for the first three to four months." The manager also told us that they had not been involved in putting together the action plan; even though the action plan stated that it was completed by them along with two others.

There had been some concerns raised about the service since our last inspection. A member of staff had contacted the local authority with concerns about some of the behaviour of some staff at the home whilst supporting people. These were concerns about certain staff members being emotionally abusive and bullying people at the home during the evening. Once these allegations had been made by this staff member; other members of staff came forward with similar allegations.

The manager responded to these allegations. They were open about these allegations and had took action

with regard to the specific staff members named, to ensure people were safe. What is of concern is that there is evidence that this may have been happening for some time before concerns were raised. This calls into question the culture within the home; one where staff members may not have felt safe raising alerts.

We asked what checks had been done to ensure the quality of support for people during the evening when there may be less staff members about. We were told by the manager that unannounced visits had been done during the day and at weekends, but that no checks had taken place in the evening or night since these concerns had been raised.

Another concern was raised by the manager about the way staff at the home recorded allegations made by people living at the home. The manager had been told by staff that notes had been made in an "allegations book". The manager was unaware of there being an allegations book. When the manager looked at this book it showed that there was a system that had historically been used by staff that was outside of the organisations incident and complaint recording system. When the manager became aware they alerted the local authority safeguarding team to the allegations contained in the book.

A managing director of the provider told us that neither the home manager or area manager had any knowledge that staff had this system in place. The book contained information about incidents and allegations people had made since June 2013. Most of the information was from previous years and we saw that when the manager and area manager had become aware of the book, they had reviewed the information and had made appropriate safeguarding referrals to the local authority.

What is of concern is that there was a culture within the home that allowed this second system to be in place outside of the knowledge of managers. Or, managers were aware of the "allegations book" and allowed this system to operate outside of their organisations records. Both scenarios highlight concerns about the leadership within the home.

We have ongoing concerns about the leadership and culture within this home. We spoke with a managing director about this who told us they were aware of the importance of a positive culture at a service. They told us they will support the manager of the home by attending team meetings, had made an unannounced visit to the home and planned to do more of these. They told us that during the unannounced visit they had seen "some competency" by staff. But they said, "We need more attunement with regards to culture." The managing director told us that they had recruited a deputy manager as the manager cannot make changes from the office and needs more of a presence at the home to affect change, and the deputy manager helping will allow the manager to do this. We saw in the August team meeting notes, that the manager had noted, "The culture in Acrefield needs to change."

However, this is the third inspection where we have concerns about the culture and leadership within the home. We had highlighted to the provider our concerns twice in our reports in February and November 2017, that people at the home were not always treated with dignity and respect. After the inspection in November 2017 the provider gave the CQC an action plan with regard to the culture within the home that allowed people to not always be treated with dignity and respect. The action plan was thorough, creative and comprehensive. However, we found that much of it had not been achieved.

The provider or manager could not tell us what actions had been taken to implement cultural change. The provider was for the most part still in the planning stage for improving the service provided for people. One senior member of staff told us they had, "Lots of plans." Another member of staff told us, "We've had staff meetings and talked about the future." A third told us, "Since [new manager] came, we have ideas for changes."

The manager told us that key staff had not been in place since they arrived at the service, they told us that they needed them for support. The manager told us that when these key staff are in place their time will be freed up to lead the service more effectively. The manager added that at the moment, "I know people but don't know them well enough."

There were arrangements in place to review people's support and to decide if the home was able to fully meet their needs. The provider told us they were having discussions and are putting together plans about how the home will best meet people's needs in the future.

Whilst we have seen that some steps have been taken and there are plans being formulated. In the timescale since we have raised concerns with the provider this response has been inadequate. The service appeared aimless, with leadership that had not been effective in setting direction or having a positive impact on the culture within the home.

We would have expected that the actions the provider told us they would take in the action plan would have been an organisational priority and they would have invested in addressing change. Even more so in when taking into account the further concerns highlighted since our last inspection in November 2017.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the provider had not taken adequate steps to assess and improve the safety and quality of the service provided for people.

The manager and staff told us that there had been changes to how staff worked on a rota basis. Previously there had been set teams of staff on different "shifts", the manager told us they believe that this may have contributed to in fighting amongst staff teams. Now they are no longer working in set teams so staff have a mix of colleagues who they work with.

Staff members told us that they felt the new manager was positive and approachable. They told us that the team changes had been positive in that people no longer work in set teams and work alongside all of their colleagues.

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 Because the provider had not ensured that people's care and support met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Because the provider had not taken adequate steps to assess and improve the quality and safety of the service provided for people.