Mr & Mrs A J Bradshaw

Derwent House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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 unannounced inspection took place on 6 November 2018. It was prompted by the outcome of a safeguarding investigation which had been carried out by the local authority and the allegation had been substantiated.

At our previous inspection in March 2018 we found that the provider was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had served two warning notices and asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective and well led to at least good. At this inspection we found that the quality and safety of the service had deteriorated and there were serious areas of concerns and ongoing breaches of regulations. The overall rating for this service is Inadequate which means it will be in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Derwent House is a residential care home registered to provide accommodation and personal care for up to 14 people with a learning disability. The house is next door to another of the provider's services and has one shared bedroom and shared toilet and bathroom facilities. At the time of the inspection 13 people were living there. We inspected this service within the principles of Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion and promote people with learning disabilities and autism using the service living as ordinary a life as any citizen. We found that the model of care at Derwent House was not supportive of these principles and that people did not have choice and control over their day to day lives.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act

2008 and associated Regulations about how the service is run.

The provider had not taken action to ensure that people were safeguarded from abuse. They had failed to respond and learn lessons from an incident that had resulted in psychological abuse of some people who used the service. There were still insufficient safely recruited staff to meet people's assessed needs. The provider could not be sure that staff were trained and safe to fulfil their roles.

The service did not always provide care that promoted people's independence as much as they were able. A lack of staff and resources meant that systems and routines had been put in place which prevented people from living as ordinary life as possible. People were not always treated with dignity and their right to privacy was not always considered and respected. People's protected characteristics had not been identified or considered as part of their care planning. People did not always receive care that met their individual assessed needs.

People were able to take assessed risks when accessing the community independently and risks associated with health care conditions were minimised through risk assessment and equipment. People's medicines were stored and managed safely. Staff followed safe infection control procedures when supporting people to prevent the spread of infection.

The principles of the Mental Capacity Act 2005 (MCA) were being followed to ensure that people who lacked the mental capacity to agree to their care at the service were supported to do so.

People had enough food and drink of their liking to maintain a healthy diet. People had access to a range of health care professionals if they became unwell or their needs changed.

There was a complaints procedure. People we spoke with felt able to speak up about any concerns they had. Some people had plans put in place as to how they wished to be cared for at the end of their life.

Staff told us they felt supported and that the management was approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always safeguarded from the risk of abuse and lessons were not always learned following incidents that had resulted in harm to people.

There were insufficient numbers of staff. Safe recruitment procedures had not been followed to ensure staff were of good character and fit to work with people.

Risks associated with health and community access were assessed and minimised.

Medicines were stored and administered safely.

Control measures were followed by staff to prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's holistic needs were not being met in line with national guidance.

The provider could not be sure that staff were trained to fulfil their roles effectively.

The environment meant that not everyone had a right to privacy.

People were supported to eat and drink food of their liking.

The principles of the MCA were being followed.

People had access to a range of health care professionals if their needs changed or they became unwell.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect and their right to privacy was not always upheld.

People told us they were asked about their care and support and that their choices were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their assessed needs.

People were supported to access the local community and with hobbies and activities of their liking.

The provider had a complaints procedure.

End of life plans were in place for some people who used the service.

Is the service well-led?

Inadequate

The service was not well led.

The culture of the service did not ensure that people were provided care and support with the principles of national guidance. There was no vision or plan for future care provision.

The provider had not taken action to ensure that people were safe from abuse and had sufficient staff.

The provider's governance systems had not identified areas that required improvement.

Staff felt supported and liked the management.

Derwent House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by a notification of a safeguarding incident which had been investigated and substantiated by the local authority.

This inspection took place on 6 November 2018 and was unannounced. It was undertaken by an inspection manager.

We looked at information we hold on the service including previous inspection reports. We reviewed notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with four people who used the service and observed others care and support. We spoke with four care staff, the registered manager and the registered manager from the neighbouring service. We spoke with both of the providers.

We looked at the care records for two people who used the service. We looked at the rotas, medication systems, two staff recruitment files and the safety checks the registered manager completed.

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Inadequate

Is the service safe?

Our findings

At our previous inspection we found that the service was not consistently safe as there were insufficient staff to meet people's need safely. At this inspection we found that there were still insufficient staff and people were not being safeguarded from the risk of abuse.

We had received information from the local authority that a safeguarding allegation of psychological abuse towards several people who used the neighbouring service had been substantiated against a person who worked at the service. On the day of the inspection we found that this person had still been working at and visiting both that service and Derwent House on a regular basis. The provider had not taken action to minimise the risk of abuse occurring again and people were at continued risk of harm.

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

At our previous inspection we found that there were insufficient staff to safely meet the needs of people who use the service. We had served a warning notice and asked the provider to improve the provision of staffing within the home. We found that although staffing levels at times had been increased during the day, the evening and weekend staffing levels remained the same of three care staff to meet the needs of 13 people. One person had been assessed as requiring one to one staff support due to their complex needs. We saw that they were left at times alone and unsupervised. We observed that on one occasion when the person did not have their staff support, they picked up some play dough off the table and put it in their mouth. Another person who used the service brought this to the registered manager's attention, who then removed it from the person. We later saw this person sitting eating alone with no staff support. We saw that another person who used the service was helping them by turning the person's plate around so they could pick up the food with their spoon. The person's care plan clearly stated how staff should sit and supervise the person whilst they ate. This meant that this person was not receiving the staff support they had been assessed as requiring and this put them at risk of harm.

We observed one person became unsettled and another person came over to us and said: "I don't like it when (Person's name, hits the staff), it's not right is it". We later saw that the person who had been anxious came into the dining room and threw their knife and fork at other people sitting at the table, just missing people including the person who should have had the one to one staff support but didn't. The registered manager told us that this person required one to one staff support when they were anxious. We saw that the person's anxiety had increased lately and they had been exploring why this might be with other professionals. However, the lack of available staff meant that people were at risk when others needed support with managing their anxiety.

The provider had a dependency tool however the registered manager did not understand how it calculated the staffing hours and it had not been effective in ensuring sufficient staff. The registered manager told us that they were not aware what the staffing budget for the home was and did not have the freedom to manage the staffing levels within the home. Commissioners of people's care had also raised concerns with

the provider in relation to the staffing levels in the home however, these had not been acted upon by the provider.

This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We looked at how the provider ensured that new staff were of good character and fit to work with people who used the service. We found that the provider had not gained suitable references from previous employers for one staff member and they had received no evidence that they had the training they said they had on their application form. We also found that staff members who had a criminal record which the registered manager had known about had not been risk assessed to ensure that their performance was closely monitored. This meant that the provider could not be sure that staff were of good character and had the skills and experience necessary to fulfil their roles safely.

These concerns constitute a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that incidents of anxiety and aggression occasionally displayed by people who used the service were not being monitored. At this inspection we found that 'behavioural records had been put in place to monitor the frequency of the incidents and any identify any triggers. We saw people had risk assessments to be able to access the community independently and one person's risk associated with a health condition had been assessed and action taken to minimise the risk to the person when they became unwell.

One person told us: "I always get my medication; the staff give it me". We found that medicines were stored safely and administered by staff that had been trained to do so. Since our last inspection the provider had purchased a new medication fridge to ensure that medicines that required to be kept in the fridge were stored safely.

Staff followed safe infection control procedures and they told us how they used gloves and aprons when supporting people with personal care. We saw that the home was clean and there was antibacterial hand gel available for staff and people to use.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found that the provider did not always follow the principles of the Mental Capacity Act 2005 and they were in breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made in this area and the provider was no longer in breach of Regulation 11 (Consent). However, we had concerns in the effectiveness of staff and that the provider was not following good practise guidelines in how they supported people using the service.

People who used the service had a learning disability and associated physical and communication needs. Some people had resided at the service for many years and there were also several younger people using the service. The provider did not follow good practise guidelines in relation to promoting people's independence. Several people were independently accessing the community yet they were not being encouraged to complete their own laundry or cooking or household skills. We observed people who would be able to make simple meals with staff support sit at the dining table whilst staff served them. Although people's care was regularly reviewed there were no clear goals and aspirations of where people wished to be in the future. The registered manager told us that two people had been asked if they wished to move to more independent accommodation but both had refused. No further exploration or discussions had been had about this.

The registered manager could not be sure that staff employed at the service had the skills and training to fulfil their roles effectively. One new member of staff had declared on their application form that they had qualifications however they had not supplied evidence of them. The registered manager told us that they had asked the staff member however they had not brought them in. We saw training records of several staff members and saw there were gaps in the training and the refresher training staff were required to have. This meant that the provider could be sure that the staff employed were equipped with the skills to do so effectively.

People were supported to eat and drink, food and drink of their liking. One person told us: "We sit together and do the menus and take it in turn to have things we like on it". However, the food was ordered in bulk by the provider so people themselves were not actively involved in shopping and buying the food. We saw there were photographs of the food for people with communication difficulties. However, one person's care plan stated 'offer (Person's name) a choice before giving them the meal. We observed that at lunch time this was not done and the person was presented with one option which they ate.

The environment was designed and had been decorated to meet the individual needs of people who used the service. However, there was one double room, which two people shared. A member of staff told us that the people were great friends and enjoyed sharing. We observed that they sat at the table seemingly enjoying each other's company but there was no evidence that the decision to share a room had been discussed and agreed with them. A wet room had been installed for one person who used the service and they had a rail which had been installed in their bedroom to help them to stand with minimal support. Other people had access to a bath or a shower and there were adaptions in place to meet all people's needs.

People's health care needs were met. One person told us: "The chiropodist is coming tonight to cut my toe nails". On the day of the inspection one person was being supported to a hospital appointment for ongoing treatment. We saw that people had access to a range of health care agencies and people were supported to seek help if their health needs changed or they became unwell.

At our previous inspection we found that the provider was not following the principles of the Mental Capacity Act 2005 (MCA) and they were in breach of Regulation 11 of the Health and Social Care Act 2008. At this inspection we found that improvements had been made and they were no longer in breach of this regulation.

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 were involved as much as they were able to be in decisions about their care and support.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was now working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met and found that they were. Previously one person had been assessed as requiring a DoLS and this was not in place. Since the last inspection this had been put in place with no conditions.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had no concerns in how people were treated. At this inspection we found that improvements were required.

A recent safeguarding allegation about how some people were treated had been recently substantiated. The provider had not recognised that the way in which some people had been spoken to and about was disrespectful and unkind.

We observed that most of the interactions between staff and people were based on mutual respect for each other. However, whilst in the communal area with several people present we observed that one person was being supported to go to the toilet. One staff member said to another: "Where are you going?", and the staff member replied: "I am toileting (Person's name)". This was repeated as the staff member did not hear first time round. This was overheard by several people in the vicinity and one person who used the service began to repeat the sentence over again saying, "Toileting (Person's name), Toileting (Person's name)", as if mimicking the member of staff. This interaction did not respect the person's right to have their personal care needs met in privacy.

We saw that people who used the service from the neighbouring service walked into Derwent House without knocking and sat at the dining table with the staff member who was supporting a person with their identified one to one care. The registered manager from the neighbouring service told us: "I am trying to change the culture, it's like a community and it should be like someone's home". This meant that people's right to privacy within their own homes was not being considered and discussed with them to ensure they were happy with the current arrangements.

Two people who used the service shared a bedroom. Staff told us that these people were happy with this arrangement, however we could see no evidence of this being discussed and agreed with them. This meant that these people's right to be able to have privacy had not been considered and was not available to them if they chose to spend time alone in their room.

Two people we spoke with told us that they had meetings about the menus and that they were free to make choices about their daily routines. We observed that people got up when they wished and two people had chosen not to attend an activity on the day of the inspection and this choice was respected.

We observed that one person became distressed and upset. The registered manager supported this person at this time to become calm in a kind and caring manner.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns in the responsiveness of the service. At this inspection we found this area required improvement.

Some people who used the service accessed the community independently and would have been able with staff support to learn skills in caring for themselves within the home, such as cooking, washing and cleaning and other household tasks. The lack of available staff meant that systems had been put in place for meals to be prepared by staff, and household tasks were completed by staff on a rota basis, such as bedroom cleaning. This meant that people's care was not always responded to and personalised to meet their individual needs and preferences. People's independence was not always being promoted and people may not have been reaching their full potential to achieve a valued lifestyle.

Everyone had a care plan which supported staff to have the information they needed to support people. However, they were not always followed. We saw one person's care plan stated that a member of staff should sit with them whilst they were eating and that they should be offered a choice of meal. We observed that this did not happen and the person was presented with a meal and left alone to eat it.

We asked the registered manager if anyone who used the service had any specific cultural, spiritual or sexual needs protected under the Equalities Act 2010. They told us that no one had any specific needs however we could not see in people's care plans that this had been discussed with people or their relatives to ensure that they had been identified.

People participated in social and community activities. Some people completed voluntary work and others attended local day activities for people with learning disabilities. People we spoke with told us they were happy with the activities they were involved in.

There was a complaints procedure and two people we spoke with told us that they would speak to the staff if they had any concerns. The registered manager told us that there had been no recent complaints, however the negative feedback received from the one of the questionnaires had not been dealt with.

There was no one receiving end of life care at the service. The registered manager told us that some people's relatives had funeral plans in place for their loved ones and these were readily available in their care plans if needed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found that the service was not consistently well led. We had asked the provider to improve. Although the provider had made some of the required improvements we found further concerns.

At our previous inspection we found the provider in breach of Regulation 18 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 (staffing) and Regulation 17 (Good governance). We had served a warning notice for each regulation. At this inspection we found that the provider had not made significant improvements and they were still in breach of both of these regulations.

Although we had been informed that the staffing levels had been increased since the last inspection we found that this was not the case and the provider remained in breach of Regulation 18. The rotas reflected that the staffing levels had remained the same specifically in the evenings and the weekends. From our observations on the day of the inspection there were still times that people were not getting their assessed needs met due to a lack of staff. This meant that the provider had not taken action to ensure people's needs were safely met by sufficient numbers of staff.

We found that the provider had not taken action to minimise the risk of abuse to people by taking action following a recent safeguarding investigation which had been substantiated in a neighbouring service. People living in Derwent House were also at risk due to the ongoing contact from the person involved with the service. The provider had not learned lessons from the investigation and looked at how the interactions between themselves, staff and people should be based on a professional approach at all times.

The provider had not ensured that staff working at the service were suitable and safe to do so. This meant that people were put at risk as the designated quality checks had not been carried out and any risks identified with individual staff members had not been assessed and minimised prior to them working with people.

The registered manager showed us that some people who used the service had completed a questionnaire about the quality of the service they received. However, the feedback from these had not been analysed and we saw that one person had ticked a box to say they were unhappy with the bedtime routine. This meant that this questionnaire was not effective in ensuring that it drove improvements for people.

The provider's governance systems had not been effective in ensuring that people were receiving care that was safe and met their holistic needs. The culture of the service was not following the national guidance in how to support people with learning disabilities to live in the community. Some people had resided at the service for many years and they were restricted in their opportunities to learn new skills and work towards independence by the staffing levels. Routines and systems had been put in place which restricted people's ability to be as independent as they were able to be. The provider told us that the funding they received was not sufficient to be able to create the environment conducive to meeting the best practise guidance. However, there was no clear strategy or vision for the service of how they should work towards delivering

care in line with the national guidance now and in the future.

These issues constitute an ongoing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 18 Registration Regulations 2009 as they had not notified us of significant events and also the requirement to display their previous inspection rating was not being met. We found that the provider had taken action to ensure that both these issues were now being complied with.

At our previous inspection we found that the registered manager had received no support or supervision and at this inspection this appeared to be the same. The registered manager did not respond when we asked what support they had to fulfil their role. Since the last inspection the registered manager had implemented behaviour monitoring records and a system to monitor DoLS applications which we had previously identified as requiring.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always being protected from potential abuse following allegations being substantiated.

The enforcement action we took:

Notice of Proposal, followed by a Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Insufficient action had been taken to resolve issues identified in a previous inspection. Lessons were not always learned following safeguarding investigations. Governance systems were not effective.

The enforcement action we took:

Notice of Proposal, followed by a Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always safely recruited as references were not always checked and staff with criminal convictions did not always have their suitability to work with vulnerable people who used the service risk assessed.

The enforcement action we took:

Notice of Proposal, followed by a Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to support people effectively. Improvements had not been

made since the previous inspection in relation to staffing levels.

The enforcement action we took:

Notice of Proposal, followed by a Notice of Decision.