Hoffmann Foundation for Autism

Hoffmann Foundation for Autism - 4 Park Avenue

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 inspection took place on 22 and 28 November 2017 and the first day of inspection was unannounced.

The Hoffmann Foundation for Autism – 4 Park Avenue is a residential care home registered to provide accommodation and personal care support for up to six people who have learning disabilities and may have autism, Asperger's Syndrome or display characteristics that fall within the autistic spectrum disorder. At the time of our inspection, four people were living at the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

We last visited this service on 25 July 2017 when we carried out a focused inspection to check if the service had followed their action plan to meet the legal requirements and we found them to be in breach of three Health and Social Care Act 2008 (Regulated Activates) regulations in relation to safe care and treatment, good governance and staffing. We also found the service was in breach of Care Quality Commission (Registration) Regulations 2009 in relation to notification of other incidents. The service was rated Requires Improvement. At the last comprehensive inspection on 18 and 26 August 2016 we found the provider was in breach of two regulations in relation to safe care and treatment and good governance and the service was rated as Requires Improvement.

There was not 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 Head of Operations was undergoing the registered manager registration process with the Care Quality Commission. In the meantime, the service was managed by the deputy manager and the supporting manager. There had been four managers since August 2016 and there had not been a registered manager since November 2016. This did not assure us that the service was well-led.

At the inspection on 22 and 28 November 2017, we found that the provider had not made sufficient improvements and were in breach of legal requirements.

Risks associated with people's health and care were identified but not appropriately assessed. People's care plans and risk assessments were not reviewed and updated when people's needs changed. A person's unexplained injury was not investigated and reported to the local authorities in a timely manner. The service did not have systems to ensure lessons were learned following incidents to prevent them from recurring. Staff understood their role in safeguarding people against harm and abuse, and knew how to identify and report abuse.

The medicines cupboard temperature was not always recorded. Staff rotas were not consistent and staff were not appropriately deployed to meet people's social care needs. The service had not promptly involved healthcare professionals in assessing people's needs.

People did not always receive dignity in care. Not all staff were trained in equality and diversity and dignity. The service did not engage with people in seeking their feedback about the quality of care delivery.

The service did not maintain effective infection control practices. There were several maintenance and repair issues that had not been fixed and posed safety concerns. The service was not clean and a person's bedroom had malodour.

The service's audits and monitoring checks did not always identify gaps and areas of improvement to ensure the quality and safety of the service delivery.

Staff followed safe medicines administration practices and we did not find any gaps in medicines administration records. The service followed appropriate recruitment procedures to ensure people were supported by staff that were suitable for the job.

Staff received regular support and supervision. Staff were aware of people's needs, likes and dislikes and met those needs. People liked the food and staff maintained accurate records of people's nutrition and hydration intake. The service operated within the legal framework of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People shared positive and caring relationships with staff. Relatives told us staff were caring and friendly. People's cultural and spiritual needs were acknowledged and supported when required.

Staff supported people to remain as independent as they could be. People's relatives were promptly and regularly informed about their family member's health and updated on any changes. The provider responded to complaints in a timely manner.

We made recommendations in relation to end of life care and specialist assessment of nutrition and hydration, and personal hygiene needs.

We found the registered provider was not meeting legal requirements and there were six breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations. These were in relation to person-centred care, dignity and respect, staffing, safe care and treatment, premises and equipment, and good governance.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within the 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?

Inadequate

The service was not safe.

People's risk assessments were not updated and reviewed when people's needs changed. The provider had not investigated and reported an incident as per their own policy.

Sufficient numbers of staff were not deployed to ensure people's individual needs were met.

People were exposed to risks of infection. The premises were not clean and there were several health and safety concerns that had not been addressed in a timely manner.

Medicines cupboards temperatures were not always recorded.

People were happy with the medicines support and relatives told us staff provided safe care. Staff understood risks to people and how to identify and report abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs were not assessed appropriately. Healthcare professionals were not consulted whilst assessing people's specific health needs.

People enjoyed the food and were supported by staff who understood their needs. People's daily care records gave information on how people were supported.

Staff received regular training and supervision to do their job effectively.

The service applied for Deprivation of Liberty Safeguards in a timely manner and staff sought people's consent before supporting them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's rights were not always respected. People were not always able to access the community when they wished. The environment people were living in did not promote people's dignity. People's needs were not always met in a dignified way.

People and staff shared positive relationships. Relatives told us staff were caring.

People's cultural and religious needs were recorded.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not reviewed to reflect a change in their needs. The service did not request care reviews to ensure people were receiving care that met their needs.

People were not always able to carry out their weekly planned activities.

People's care plans gave information on their likes and dislikes, and staff were aware of people's wishes. Staff supported people to draw up their weekly activities plan.

Relatives were happy with how complaints were addressed. The service maintained accurate records of complaints.

Is the service well-led?

Inadequate

The service was not well led.

The service's audits and checks were not effective and did not identify gaps and issues with the safety and quality of the care delivery.

Not all staff felt supported and there was a lack of a stable management presence. People's feedback was not sought on the quality of the service.

Relatives were happy with the service and found the management approachable.

Relatives' survey results were positive and an action plan was created following the survey results.

Hoffmann Foundation for Autism - 4 Park Avenue

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 22 and 28 November 2017 and the first day was unannounced. The inspection was carried out by one inspector.

Prior to our inspection, we reviewed information we held about the service, including previous reports and notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We contacted the local authority about their views of the quality of care delivered by the service. Due to technical problems, the provider was not able to complete a 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection, we met all four people living at the home. We spent time observing interactions between people and the staff who were supporting them. We spoke with two people using the service, six staff including the deputy manager, the peripatetic manager, the head of operations and three care staff. We reviewed four people's care records including care plans, behavioural plans and risk assessments, their medicines administration records and daily care records. We looked at four staff files including their recruitment, training and supervision records and two month's staff rota. Following the inspection we spoke with two relatives, a social worker, environmental health inspector and spoke again with one of the commissioning bodies.

We looked at accidents, complaints and safeguarding records, staff team meeting minutes, quality audits

and health and safety, maintenance and monitoring checks. We reviewed the documents that were provided by the service on our request after the inspection including policies and procedures, three people's care plans and risk assessments and improvement action plan.

Inadequate

Is the service safe?

Our findings

During our previous focused inspection on 25 July 2017, we found the service was not safe because some safeguarding adult concerns were not being reported to the appropriate authorities, and there was no oversight to ensure the correct actions to investigate accidents, incidents and safeguarding concerns were taken.

At this inspection we found the provider had not made sufficient improvements and had neither investigated nor reported a safeguarding concern to the appropriate authorities.

During the inspection, the management told us there had not been any safeguarding concerns since the last inspection and safeguarding records seen confirmed this. However, we found a body map in one person's care plan that had recorded an unexplained bruise. We asked the deputy manager for further information on this including the accident and incident form, investigation records, outcomes, lessons learned and safeguarding alert form. Following the inspection, the provider sent us the accident and incident form, daily care and communication book records where staff had recorded the unexplained bruising and the supporting manager's conversation notes with the shift leader. However, we found the accident and incident form was not fully completed; the section to be completed by the 'responsible person', who would have been someone in the management team, was blank. The management told us they decided not to investigate and report this unexplained bruising as the person was prone to walking and bumping into things and they had assumed the person had bumped into something and bruised themselves. We looked at this person's care plan and risk assessment; there was no information about the person being at a risk of walking and bumping into things and of frequent bruising. There were no previous incident records of unexplained bruising.

We looked at the provider's accident and incident policy and under unexplained injuries it clearly stated that "a safeguarding alert will be raised to the local safeguarding adults' team." We spoke to the local authorities including the commissioning team and the borough where the service is located regarding their expectations in relation to unexplained bruising. They confirmed the provider should report any unexplained bruising to the local authority. This meant the provider failed to adhere to their policy and procedure, to identify and report a safeguarding concern to appropriate authorities, and to appropriately investigate the incident. The provider did not maintain records of lessons learned to prevent future recurrences. This put the person at a risk of avoidable harm.

People were not always protected against avoidable harm. There were risk assessments in place specific to people's individual health and care needs, and included measures to minimise and manage those risks. However, they were not always reviewed and updated appropriately and in response to changes in people's needs.

For example, one person's risk assessment had not been reviewed and updated to reflect the reduction in their allocated staffing levels since their care review in February 2017. When accessing the community this person sometimes displayed behaviour that could challenge staff and hence they were initially provided

with a two staff support care package when going out into the community. However, in February 2017, following a care review, the local authority reduced staffing support from two to one. The provider had not updated risk assessments and did not give revised instructions to staff on how to safely support the person in the community. Some staff had informed the management that they did not feel safe and confident in supporting the person on their own in the community. Following the inspection, the deputy manager sent us an updated risk assessment and we saw that while the staffing ratio had been amended to reflect the decrease in staff support the mitigating factors were exactly the same as they were when the person was being supported by two staff. This meant the management had not conducted a risk assessment to ensure the person was receiving appropriate support with their accessing community needs. This put the staff and the person at risk of harm.

On day one of inspection, we found there were no paper towels, hand wash or hand sanitiser in the toilets and bathrooms. We found the sink in the kitchen under the medication cupboard did not have hand wash or hand sanitiser and paper towels. The lid of the rubbish bin that was used to throw leftover food and other cooking was broken. The service was asked to maintain detailed records for cleaning and disinfection of work surfaces used for raw meats and ready to eat foods during their August 2017 'Food Safety' inspection carried out by Environmental Health. At the inspection, we looked at daily cleaning records and found there was no information as per the cleaning and disinfection requirements set by Environment Health following their August inspection. This meant the provider did not maintain a clean and appropriate environment that facilitated the prevention and control of infections thereby putting people at risk of harm.

We looked at the medicines and controlled drugs cupboards temperature records to ensure medicines were stored at or below the required temperature. We found the provider did not maintain temperature records for the controlled drugs cupboard. The provider recorded temperatures for the medicines cupboard but we found gaps in the November 2017 temperature charts. We reviewed the provider's medicines policy in relation to medicines cupboard temperature which stated, "The temperature should not exceed 25 degrees centigrade and a temperature record must be kept". This meant the provider was not following their medicines policy and by not storing medicines at correct temperatures could mean the medicines were not effective or safe to use thereby putting people at risk of harm.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

We found a number of premises and equipment cleanliness and maintenance issues that posed health and safety risks to the people using the service. At the inspection, we found the premises and some equipment were not clean, some rooms were out of use and there was malodour. For example, the fridge and freezers were not clean, were sticky and greasy to touch and the freezer had not been defrosted for a long time. The premises had not been appropriately cleaned since the cleaner left employment in July 2017. There were cobwebs in people's bedrooms and the communal room. Windows and the downstairs shower cubicle were dirty. One person's bedroom had malodour. The management told us staff did not have time to clean the home and hence they tidied up and did the basic cleaning such as cleaned the floors and changed people's beddings.

The service's two bathrooms located on the mezzanine floor and first floor were out of use due to low water pressure and blockage issues. The bathroom that had blockage issues had malodour. We saw the maintenance book that showed there had been low water pressure issues since July 2017. We saw one person's bedroom walls had water leakage stains. The kitchen and front doors had been damaged and not been properly repaired which was a security issue. The flooring leading to the kitchen and flooring in two people's bedrooms was uneven. Carpet outside two people's bedrooms was ripped off the floor, frayed and

with no underlay. The above were trip hazards and safety concerns. Staff had identified and reported these risks but no action had been taken.

The provider had not appropriately maintained the premises and there were cleanliness, safety and security issues that put people using the service at risk of avoidable harm.

The above issues were a breach of Regulation 15 of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

The management told us staffing levels were in line with people's needs. However, on our inspection days, we found staff were not able to support people's individual social care needs in the evening hours due to shortage of one staff member. For example, on day one of inspection, we saw two people staying at home in the evening instead of visiting their choice of pubs as per their chosen planned activities. On the second day of inspection, we saw one person unable to go out for a meal as per their planned activities again due to shortage of one staff member. We looked at the staff rotas to identify staffing levels, but found they were inconsistent and difficult to follow. For example, on some days there were three staff and other days only two. We asked the management about this and they agreed the staffing allocations were inconsistent. Staff we spoke with all gave conflicting replies in terms of staffing numbers. This meant there were not always sufficient numbers of staff to meet people's individual needs.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

Following the inspection the provider sent us an improvement action plan to address premises maintenance issues. The management told us they had hired a cleaner who was due to start soon. The provider had put hand wash and paper towels in all the required areas and new bins with secured lids had been purchased for the kitchen area.

The management reported the unexplained bruising to one person using the service to the local authorities following this inspection. We confirmed this by speaking to the local authorities. Staff we spoke with were able to describe types and signs of abuse and how to report any concerns of poor care and abuse. In the entrance hallway information was displayed for people using the service, staff and visitors on safeguarding and whistleblowing procedures in the event of poor practice.

People had individual risk assessments specific to them, for example, personal care, epilepsy, nutrition and hydration and medicines. Measures were identified in the plans to minimise the risk to people. Staff we spoke with displayed a good understanding of risks associated with people's health, care and mobility needs. For example, we saw staff had identified and recorded tripping and health and safety hazards in relation to the premises in the maintenance book and reported them to the management in a timely manner. There were personal emergency evacuation plans in place that detailed the support people required to evacuate in the event of fire. Regular fire drills were conducted and all the relevant records were up-to-date. We reviewed water and electrical tests, these were all in date. Window restrictors were in place.

People were happy with medicines support. There had been one medicines administration error that had been appropriately dealt with and clear records were in place to demonstrate the doctor had been contacted promptly and the staff member was given a refresher session. Staff told us they received appropriate safe medicines administration training. We checked medicines administration records and conducted a medicines stock check. We did not find any gaps in the records and there were correct amounts of medicines in the blister packs. Medicines and controlled drugs cupboards were locked and secured to

walls and only accessible by the staff administering medicines.

The service followed safe recruitment practices and carried out appropriate checks including criminal record and reference checks to ensure staff were vetted and had the appropriate skills and knowledge before they started working with people using the service.

Relatives told us staff supported their family members in a safe manner. One relative commented, "I know for sure when I leave the home that she [person using the service] is in safe hands." Another relative told us, "I absolutely believe he [person using the service] is safe at the home."

Requires Improvement

Is the service effective?

Our findings

At our previous focused inspection on 25 July 2017, we found some gaps in staff training, and not all staff were provided with sufficient training to do their job effectively.

During this inspection we found the provider had made improvements and staff were provided with sufficient electronic and face to face learning opportunities.

We looked at the staff training matrix that showed training that staff had completed and the training staff needed to attend with planned training dates. Staff told us they were given plenty of training opportunities and felt confident in their roles. One member of staff told us "I have been sufficiently trained". We looked at staff training records which showed staff had received mandatory training such as safeguarding and health and safety, and specialist training such as Autism awareness, challenging behaviour, person centred planning and epilepsy. All new staff received detailed induction training followed by specialist training. Existing staff received regular refresher training and records seen confirmed this.

We observed people being supported with their needs by staff who knew and understood their individual needs and abilities. Staff were able to describe people's health and care needs, and abilities. Relatives told us staff provided effective care and met their family members' needs. However, we found the provider did not always involve relevant health and social care professionals in assessing, planning and delivering services to meet people's individual care needs. For example, one person's health action plan stated "as I no longer have teeth; my foods should be soft and cut" however, there was no indication if the provider had involved a speech and language therapist in assessing the person's nutrition and hydration needs to conclude they required soft food. Another person had recently started using a shower chair instead of having a shower standing up. However, there was no indication of this in their care plan and no information on whether an occupational therapist was involved in the decision making. We asked the management about this and they told us the assessments were not appropriately carried out in conjunction with the suitable therapists and would request referrals immediately.

We recommend that the service seeks advice and guidance from a reputable source about providing specialist assessment and support to meet nutrition and hydration, and personal hygiene needs.

Staff received one to one supervision every six to eight weeks and an annual appraisal. We looked at staff supervision records and appraisal records; they indicated staff received regular supervision and a yearly appraisal. Staff confirmed this.

Staff supported people on a weekly basis to choose and prepare their menus with the help of pictorial menus. People were given a choice of cereals and cooked options for breakfast, they usually ate lunch either at the day centre or at the café of their choice. The staff prepared and cooked evening meals as per people's choice. On both inspection days, we saw people enjoying freshly made appetising meals by staff. People were supported to make hot and cold drinks and to eat a healthy diet. We observed people were comfortable in the kitchen and dining area and they approached staff for drinks and snacks. We looked at

people's daily care logs and found they were completed twice a day and gave information on how people were supported including their nutrition and hydration needs.

Relatives told us people received good support to access health and medical services. One relative told us "She gets taken to dentist regularly". All people were registered at the same doctor's surgery and were supported to access it when required. People went for annual check-ups and their medicines were regularly reviewed by the doctor. We saw records of regular check-ups and medicines reviews. We saw records of healthcare professional visits such as the dentist, doctor, chiropodist and optician.

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.

People living at the service did not have the capacity to consent to care and treatment. As per the requirements the service had applied for DoLS on people's behalf and had requested reviews of people's DoLS authorisation in a timely manner. However, we found two people's most recent DoLS authorisations were not in their folders. The management told us they could not locate recent DoLS for the two people due to the poor filing system maintained by the previous management. Following the inspection the provider sent us DoLS review forms and follow up correspondence with the local authority.

Staff we spoke with demonstrated a good understanding of MCA and DoLS and told us they sought people's consent before providing care, gave them choices and supported them in making decisions.

Requires Improvement

Is the service caring?

Our findings

Relatives told us staff were caring and helpful. Their comments included, "Carers are wonderful, absolutely wonderful. She [person using the service] is happy living there" and "Staff interacts very well with him [person using the service] and he seems happy. Staff are caring and kind." We observed positive interactions between staff and people. Staff were patient with people and listened to their requests attentively.

However, we found the environment people lived in did not promote people's dignity and did not respect their rights. People's rooms had not been cleaned properly for the last five months since the cleaner stopped working; there were cobwebs in people's bedrooms, people living on the mezzanine floor and first floor could not use bathrooms and toilets on their floors due to low water pressure and plumbing issues.

People were not supported to meet their needs in a dignified way. For example, one person was given an open bucket to urinate in at night in order to prevent them from urinating on the floor. The provider had not carried out an assessment or a care review to decide the best way to encourage the person to use the toilet and meet their personal hygiene needs. We looked at this person's person centred care plan and found under 'hopes and dreams for future' and 'my action plan' it stated "To use the bucket in my bedroom to urinate in rather than the floor."

There were no records to demonstrate any discussions had taken place around options considered to support the person in a dignified way to encourage them to not urinate on the floor such as using a commode. Commodes are portable toilets used by people with reduced mobility who are unable to use a conventional toilet. This meant the service did not involve the person in making decisions about their care and support.

We asked the head of operations about the use of an open bucket and they told us that they were not aware of it and that it was not part of the person's behavioural management plan, either. They further said an urgent assessment would be carried out to identify how best to support the person to meet their needs.

People were not always supported to be involved in the community as per their wishes. The provider did not appropriately plan staffing numbers to ensure people were being supported to access and get involved in the community as they wished. People were not informed about the reasons why they were unable to go out in the community to undertake their planned activities.

The management told us they had recently introduced equality and diversity, and dignity training. We looked at the staff training matrix that showed out of 10 staff only three had received training in equality and diversity, and no staff had been trained in dignity.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

The provider worked well with people's relatives in encouraging them to express their views regarding their

family members' care. Relatives told us they were frequently contacted by the management in relation to their family members' care. Relatives told us staff treated people with dignity and respect.

Staff told us they gave people choices, did not rush them and supported them at their pace, encouraged them to make decisions, knocked on their doors before entering and speaking to them with respect and politely.

The service asked people about their cultural and religious and spiritual needs, and these were recorded in their person centred care plans. People were supported in meeting their cultural and religious and spiritual needs. For example, one person was supported in singing religious hymns and in celebrating their religious festivals. Staff ensured that another person was given their cultural food which they enjoyed whenever the person wished.

People were encouraged by staff to remain as independent as they were able to be. During inspection, we saw staff encouraged people in daily living activities such as in laying the table for dinner, folding their dry laundry and making hot drinks. One relative commented, "She is very well settled at the home and never seen her so independent."

We saw people's personal and sensitive information was stored safely in lockable cupboards which meant that their information was kept confidentially.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed at the time of referral, and care plans and health action plans were drawn up following people's initial needs assessment. The provider had recently introduced new person centred care plans that were in the process of being completed and finalised. The service developed detailed behavioural management plans for people with behaviour that could challenge the service and instructed staff on how to support people with their individual behavioural needs. We looked at people's person centred care, health action and behavioural management plans and found them to be comprehensive.

However, we found people's care plans were not always reviewed and updated in a timely manner when their needs changed. For example, the care package for one person had changed since February 2017 and staff reduced from two staff to one staff member to support the person to go out in the community but their care plan had not been reviewed to reflect this change. Since the change to the care package, the person had not been able to go out in the community as often as they used to. However, this had not been fed back to the social worker and the provider had not requested a care review to ensure the person's needs were appropriately assessed so that they received suitable care support. This meant the provider did not do everything reasonably practicable to ensure the person using the service received person centred care that met their needs and reflected their personal preferences.

We looked at people's weekly planned activities and found people had not been supported to carry out their weekly outdoor planned activities. For example, on day one of inspection, we saw two people staying at home in the evening instead of visiting their choice of pubs as per their chosen planned activities. This was due to a shortage of one staff member.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

Relatives told us staff were responsive to their family members' needs and provided individualised care. One relative commented, "She [person using the service] is a different person now, change is amazing. She is now able to speak." Staff were able to describe people's individual likes, dislikes, wishes and aspirations and how they supported them. Comments included, "[Person] likes to change into a pair of shorts after returning from day centre" and "[Person using the service] enjoys cups of tea and the skipping rope provides [person using the service] comfort".

Relatives told us they were involved in the care planning process and were invited to care reviews. One relative said, "I am going to the home tomorrow to discuss changes in the service setting and I attend annual care reviews."

People's care plans gave information on people's likes and dislikes, people's background and life history, culture and religious preferences, goals and aspirations. People's medical history and health action goals were recorded in their health action plans. Staff told us the care plans were detailed and provided sufficient information about people's choices, and their likes and dislikes.

The provider had appointed an activities coordinator that worked with people across all the provider's services to formulate both indoor and outdoor activities for all the people using the services. Staff encouraged people to express their preferred activities. People were supported to carry out indoor activities of interest to them. For example, one person liked playing dominoes, we saw this person play dominoes during inspection visits and found this recorded in their care plan. During inspection visits we saw staff supporting one person to play ball games such as catch and another person solving puzzles.

The service encouraged relatives to raise concerns and complaints. Relatives told us the staff and management were good at listening to their concerns and addressing their complaints in a timely manner. One relative commented, "Yes, they [the manager] would address my concerns straightaway. I never got an impression that they were trying to hide anything." Another relative said, "When I visit the home, staff always asked me if I had any concerns or wanted to make a complaint."

The service kept clear and accurate records of complaints and maintained a complaints log detailing dates of complaints received, of what nature, about whom, by whom, what actions were taken, when they were closed and at what complaint stage. The records confirmed the management responded to complaints as per the provider's complaints policy.

We looked at people's person centred care plans and found no evidence that end of life care had been considered or discussed with people or their representatives.

We recommend that the service seeks advice and guidance from a reputable source about end of life care discussions with people with learning disabilities.

Inadequate

Is the service well-led?

Our findings

During our previous focused inspection on 25 July 2017, we found the service did not have a registered manager, it lacked a stable management presence and the provider had not notified the safeguarding authority and CQC of a safeguarding case.

At this inspection we found the provider had not made sufficient improvements and had failed to notify safeguarding authorities of unexplained bruising to one person who used the service. The Head of Operations had applied to register with CQC as a manager and was awaiting their interview.

Following the inspection, we were notified that the Head of Operations had passed the interview and were now the registered manager of the service.

We received mixed feedback from staff in regards to management support. Some staff told us they felt well supported by the management whereas others said due to not having stable management they did not feel well supported. The service lacked systems to promote effective communication where staff were informed on changes to people's needs and aspects relevant to their role in a timely manner. This meant staff were not enabled to deliver individualised care to people using the service. We looked at the team meeting notes for the last year and found the team meetings format had changed in the last six months. People's healthcare needs were no longer discussed. Any changes relevant to the care delivery were mainly communicated to staff via a communication book. For example, staff were informed regarding changes in the staffing levels for one person via the communication book and not in a team meeting. Staff were not asked if they felt confident and comfortable supporting the person on their own in the community. This meant the person was not always supported to access the community and did not receive care as per their care plan.

The management carried out regular internal audits however, the audits were not always effective in identifying gaps in the records relating to people using the service and to ensure they were accurate and up to date. The management had not recognised gaps and issues that we identified during this inspection. Staff were not appropriately deployed to meet people's individual social care needs and staff rotas were inconsistent and difficult to follow. People's care plans and risk assessments were not reviewed following a change in their needs and care package. For example, the management identified a person to be at a risk of falling in the shower and had introduced a shower chair; however, this change was not reflected in their care plan and risk assessment. The provider had not requested a care review with the local authority to ensure the person's individual needs were met. People were not always involved in making decisions about their care and support, and they were not always supported in a dignified way. Not all staff received training in equality and diversity and dignity. Two people's DoLS authorisations could not be located and the last ones in the files were from 2014. The medicines and the controlled drug cupboards were in the kitchen which meant there could be an issue of the temperature going above the recommended medicines storage temperature. However, we found medicines storage temperature records were not appropriately maintained. This put people at risk of receiving care and treatment that was inappropriate or unsafe.

The provider had not carried out improvement actions in relation to cleaning schedules following the August 2017 food hygiene inspection. The provider did not maintain good infection prevention practices including cleanliness. The service had not had a cleaner since July 2017 and no one was appointed in the interim to ensure people using the service had a clean place to live in. We found several maintenance and health and safety issues recorded in the maintenance book that had not been actioned and signed off. For example, staff recorded on 10 August 2017 "the kitchen entrance door broken- still not repaired", and on 7 July 2017 "carpet on the top floor ripped and turned-still not fixed". At the inspection, we found these health and safety issues had not been addressed. The service lacked effective audit and monitoring systems and processes to ensure the safety and quality of the care delivery.

The service did not engage with people on a regular basis to seek their feedback on the quality of care delivery and to find out if they liked living at the home.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

Relatives told us they found the management approachable and they were contacted in a timely manner in relation to their family members' healthcare issues. They further said people were happy living at the home and liked the staff. Most staff told us they enjoyed working at the service.

The service asked relatives formally for their feedback on an annual basis and areas of improvement were identified and an action plan created to address them. We looked at an analysis of the results of the relative's survey and an action plan to address areas of concerns. The feedback was overall positive. Some of the completed action points from the action plan were recruiting a new activities coordinator and reviewing and introducing new staff induction training.

The service worked with the local authority, local Mencap, advocacy services and procurement teams to meet people's needs.

Following the inspection, the Head of Operations promptly submitted an action plan stating how they would address all the issues found during this inspection.