Parkcare Homes (No.2) Limited

Autumn Leaf 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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 August 2017. The inspection was unannounced. However, the publication of our report was delayed. This was because following our inspection visit we received further information of concern from a member of the public, which was being investigated by the local safeguarding team and the provider. We wanted to ensure this information was included in the inspection report.

Autumn Leaf House is registered to provide accommodation and personal care within a residential setting to a maximum of eight people. There were four people using the service at the time of our inspection. This included people with a learning disability and autism.

The service was registered with us in September 2016 and this was the first time we had inspected the service.

Prior to our inspection visit we had been informed of concerns received by the local authority commissioners of adult social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. These related to some people not being supported safely and not receiving their medicines as prescribed.

After our inspection visit a member of the public contacted us expressing concerns that risks to people who lived at the home were not being effectively managed to maintain their safety, and alleging the behaviours of some staff was inappropriate. They also alleged incorrect restraint had been used for a person and an unauthorised restriction placed on their liberty. Concerns were also expressed about the management of the service.
We informed the local safeguarding team and also the provider who had taken these concerns seriously. They conducted an internal investigation and the local authority had placed a suspension on new placements to the service whilst investigations were being carried out by commissioners and the safeguarding team. This was to ensure all concerns identified had been addressed and people being supported by the service were safe.

At the time of our inspection there was no registered manager at the service. A requirement of the provider's registration is that they have a registered manager. 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 service had experienced a number of changes since registering with us. There had been inconsistent managerial oversight of the service since September 2016 and staff told us they had found this unsettling. Some staff did not feel confident concerns raised with the management team were dealt with effectively. Most relatives felt people were safe at Autumn Leaf House, but they were concerned the constant managerial and staffing changes at the service had unsettled their family members. Three separate

managers had been supporting the service and a new manager had recently been employed. This person was planning to register with us; however we were informed by the provider they had now left the service.

At times there had not been enough staff at Autumn Leaf House to support people and monitor their safety. There had been a large turnover of staff which meant people did not always receive care and support from staff who they were familiar with. The provider had not consistently ensured that people were supported by staff who had the necessary skills or confidence to support people. In addition the provider had not ensured risk management plans to keep people safe, were consistently followed.

The manager and staff knew what procedures to follow to report any concerns but did not always follow guidance to keep people safe. Staff had an understanding of risks associated with people's care needs and how to support them; however these were not consistently managed. Recruitment procedures tried to ensure staff were of a suitable character to care for people at the home.

Medicines were stored and administered safely, however some people had not received their medicines as prescribed. People were supported to attend health care appointments when needed to maintain their health and wellbeing.

Most staff were kind and supportive to people's needs and people's privacy and dignity was mostly respected. People were encouraged to be independent in assisting with tasks around the home and shopping. Care plans contained detailed information about people and how they liked to be supported.

The management and staff teams mostly understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and supported people in line with these principles. However, restraint used to control a person displaying challenging behaviour, was not used correctly by some staff. People were supported to make everyday decisions themselves, which helped them to maintain their independence. Where people were not able to make decisions, relatives and healthcare professionals were consulted for their advice and input.

People were mostly supported to pursue their hobbies and interests both within and outside the home. Activities were arranged according to people's individual preferences, needs and abilities; however the provider acknowledged improvements were required. People who lived at Autumn Leaf House were encouraged to maintain links with friends and family who visited them at the home. Relatives knew how to make a formal complaint and were able to discuss any concerns they had with staff. At the time of our inspection no complaints had been received.

Staff were able to discuss their own development and best practice in supervision (1:1 meetings with a member of the management team) and during team meetings. However, the programme of staff training did not always provide staff with the skills and knowledge to meet people's needs. Staff told us during the last year they had not felt supported by the provider and the constant manager and staff changes had impacted on people living at the home and staff morale. Some staff did not feel confident concerns raised to the manager were dealt with effectively.

The provider carried out audits to check the quality of care people received however, they acknowledged these had not consistently identified areas requiring improvement. The provider was taking positive steps to address issues and support the home.

We found three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. You can see what action we told the provider to take

at the back of the full version of the report.

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.

At times there were not enough suitably skilled staff to keep people safe. Relatives told us people received support from staff that understood the risks relating to people's care. However, we found identified risks were not always managed safely. Staff knew how to safeguard people from harm, but did not consistently follow guidance to keep them safe. Medicines were mostly managed safely; however some people had not received their medicines on occasions. The provider's recruitment practice and policies reduced the risk of the employing unsuitable staff. Premises and equipment were maintained and safe to use.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had received training to help them undertake their work, however further training was required. People were supported to access a variety of healthcare services to maintain their health and wellbeing. Staff were mostly aware of their responsibilities regarding the Mental Capacity Act and Deprivation of Liberty safeguards. However, techniques to restrain and control people displaying challenging behaviours were not always correctly performed by some staff.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by care workers who had a good understanding of their care needs. Most staff were kind and caring towards people and most ensured people were treated with respect, had privacy when they needed it and maintained their dignity. People were encouraged to maintain their independence and supported to make choices about how to spend their time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were given support to access interests and hobbies that met their preferences but improvements were required. The provider was looking to improve the range of activities offered. People, where possible, and their relatives were involved in decisions about their lives and how they wanted to be supported. Care plans contained detailed information about people and the support they required. Relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not ensured there was robust and consistent management of the home. The provider did not have a registered manager at the home and had been supported by interim managers. Staff, people and relatives found this unsettling; however a new manager had recently been recruited. Systems were not consistently in place to review the quality and safety of the service provided and to drive forward improvements. There were opportunities for staff to discuss issues or concerns at meetings. However, some staff did not feel confident their concerns would be dealt with effectively by the management team.

Autumn Leaf 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.

The inspection visit took place on 24 August 2017 and was carried out by two inspectors. However, the publication of the inspection report was delayed due to concerns raised by a member of the public after our visit, which were being investigated by the local authority safeguarding team, commissioners and the provider.

Before our inspection visit we reviewed information we held about the service, for example, notifications the provider sent to inform us of events which affected the service. We looked at information received from the local authority commissioners of adult social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. They had informed us of serious concerns they had received from a member of the public. These related to people not being safe at times and some people not receiving their medicines as prescribed.

During our inspection visit we observed some of the care and support provided to people who lived at Autumn Leaf House. However, our presence in the home caused anxiety for some people and our observations of how staff interacted with people was limited. Most people had limited verbal communication and were unable to tell us in any detail about the service they received. We spoke with two relatives to get their views on the care given to their family members.

We spoke with the new manager, deputy manager and the provider's Quality Improvement Lead and the Director of Quality. We also spoke with four members of support staff and a social worker. We looked at the records of four people who used the service and two staff records. We also reviewed quality monitoring records.

Following our inspection visit and on receipt of the additional information of concern, the local authority informed us they had suspended placements to the home whilst the safeguarding investigations were being

carried out. The provider had also stopped admitting new people to the service prior to our inspection visit.

Requires Improvement

Is the service safe?

Our findings

All the people who lived at Autumn Leaf House required one to one supervision from a staff member at all times to ensure they were kept safe. Prior to our inspection visit the local authority shared some concerns they had received from a member of the public that people were not always safe. These concerns related to people not being adequately supervised by staff and the management of medicines.

The information alleged two people, who had been assessed as requiring supervision, had walked out of the home unaccompanied by staff on separate occasions, and staff had to follow to escort them back. This meant people's health and well-being was placed at serious risk of harm because staff had not maintained the required level of supervision to keep those people safe. For example, one person had managed to cross a busy main road on their own. Their care plan identified they were at risk accessing the local community, as they would run away from staff. The plan stated the support of two staff was required in the community to monitor them and ensure their safety. We discussed these concerns with the manager who confirmed these incidents had taken place, but no harm had occurred to the people involved. They told us at no time were people out of sight of staff, but acknowledged that greater observation and monitoring of people should have been in place. Following these incidents the manager had reminded staff of their responsibility to keep people safe and observe them closely at all times. In addition staffing levels had been increased to provide a higher level of monitoring and additional safety measures had been introduced, such as ensuring external doors were always locked. Quotes had been obtained to provide a gate at the entrance of the home to provide additional security for people. The manager told us there had been no further similar incidents since the additional measures had been put in place.

Despite these assurances, following our inspection visit, we received further information that one person had left the home unaccompanied on the 19 September 2017, via the front door and crossed the main road unsupervised. This person had been assessed as not safe to leave the home unaccompanied. Staff had followed and assisted them back to the service unharmed; however this had again placed the person at serious risk of harm.

We contacted the provider who confirmed the incident had taken place which they had reported to the local authority safeguarding team. However, the provider at the time had not submitted a statutory notification to inform us which they are required to do by law. We did eventually receive the notification.

We also received information that alleged one person, who required the support of two staff to visit their family member, had been left at their family home and the supporting staff had left for the day. This meant the person may have potentially been placed at risk of harm as they did not have the staff available to support them. This was being investigated by the provider with the person's family.

Risk assessments identified risks to people health and wellbeing both inside the home and when taking part in activities outside the home. Risk management plans provided staff with guidance on how to manage identified risks so people were kept safe. However, these were not consistently followed to ensure people were kept safe. Staff we spoke with knew and understood the risks associated with people's care and how to

manage and minimise risks, but on occasions failed to ensure they followed the guidance provided. For example, making sure people, who following assessment, were supervised at all times to ensure they did not leave the building without support.

This was a breach of Regulation 12 HSCA RA Regulations 2014. Safe care and treatment.

The provider told us to prevent any further incidents the new gates would be installed the week commencing 16 October 2017, as a matter of urgency. In addition a key coded lock was to be installed on the front door to further improve security. The person's risk assessment had been updated and all staff informed of the importance to follow the guidance provided. We checked again with the provider who confirmed the new gates were now in place.

Information had also been received prior to our inspection visit, that people did not consistently receive their medicines as prescribed. We reviewed the provider's records and noted on four dates, between March and April 2017, some people had not received their medicines. The medicine administration records (MAR) had been signed to say people had been given their medicines, but the medication was still in the 'blister' packet. This could have placed people's health and wellbeing at risk. For example, one person had not received medicine to help stabilise their mood on five separate occasions. This meant the person's behaviour may have been affected causing them anxiety. Medicine to help the person sleep had also not been consistently administered since February 2017. This had been addressed and the person did now receive their medicine as prescribed.

To reduce the likelihood of further incidents occurring, the provider now ensured two staff members administered all medicines and both signed the MAR charts to confirm they had been given. Medicine stock levels were checked daily and after each medication round senior staff checked people had correctly received their medicines as prescribed.

However following our inspection visit, we received information of concern about the storage of people's medicines. The provider investigated these claims and informed us an issue with the storage of some medicines had been identified and this was being addressed.

Staff had undertaken training to administer medicines and had their competency checked to ensure they continued to do this safely. We saw medication audits were now conducted regularly in order to check that people received their medicines as prescribed. Staff confirmed the training they had received gave them the confidence to manage medicines safely. Staff told us, "We do online learning and we have workbooks to check we know what we are doing," and, "The training is good; it makes me feel confident I know what I am doing."

Some people required medicines 'as required'. There were guidelines for the administration of these medicines to make sure they were given safely and consistently. We asked how staff would identify when this type of medicine would be required, for example if a person became agitated or distressed. Staff were able to tell us in detail how they would observe for changes in people's behaviour and body language which might indicate the person was becoming anxious or was in pain.

Some people had behaviours that could place themselves or others at risk if they became anxious or upset. Staff knew how to manage the risk. They had been trained to 'de - escalate' situations and help people remain calm. There was clear information in people's support plans for staff to follow to manage behaviours to minimise the impact. However, information we received following our inspection visit suggested that some staff were not following the support plans. The provider investigated this and told us there was no

evidence to support the allegations. The provider added, in future to ensure all staff were fully aware of any updates to support plans they would be required to sign to confirm they had read them. The provider's senior management team and Positive Behaviour Support worker were also planning to observe staff working with people to ensure they were following support plans correctly.

During our inspection staff gave us clear and consistent information on how to recognise changes in body language and vocal sounds that could indicate a change in people's behaviour. One person became anxious when we were in their home. Staff quickly identified this and took appropriate action to keep the person and others safe.

Staff we spoke with told us dealing with some of these situations was extremely challenging and placed them under pressure for their own safety. One member of staff told us, "Incidents can be distressing, some triggers for behaviours can be clear to see, but not always. It can cause anxiety, waiting for something to happen." They went on to say although other people living in the home were not placed at risk when others displayed challenging behaviour they were often affected by what they heard and saw. On occasions this would negatively impact on people and increase their own anxiety.

The provider was aware of the difficulties staff faced and had taken positive actions to improve the well-being of people and staff. For example, head protection had been supplied for staff to prevent injury and one of the provider's Positive Behavioural Support Practitioners had been deployed to the home to support staff. They told us, "My role is to make staff feel confident to manage challenging behaviour."

In addition, to support staff further, debriefing sessions were held following incidents of challenging behaviour. This gave staff an opportunity to reflect on what went well; how they were feeling and what lessons could be learnt. One member of staff told us this was beneficial, "After incidents we have debriefs which are supportive and look to see if we could have handled the situation any better."

We asked staff if there were enough of them to keep people safe. One told us, "We went through a bad patch with poor staffing, but now we have enough." Another told us, "I think there are enough staff now, as there are seven of us today." We saw there were sufficient numbers of staff available to support people and keep them safe. The Quality Lead told us there had been several staff changes in the last year and this had meant some agency staff had been employed to support staff numbers on duty. This meant people did not consistently receive care and support from staff they were familiar with. As new staff were introduced into the home, this caused anxiety to some people and their challenging behaviours had increased, placing themselves and others at risk of harm.

One relative we spoke with told us they felt this had impacted on their relation. They said, "I think the service has gone downhill. There have been different staff coming and going and this upsets [person]. Agency staff don't know [person] and they aren't always confident at dealing with challenging behaviours." We asked if they felt their family member was safe and they told us, "Oh yes, I do think [person] is safely cared for." Another told us, "I think [person] would be safer if the staff changes stopped because [person] needs routine and staff who know him."

After our inspection visit we received further information that suggested people at the service were unhappy and their behaviours had deteriorated due to the presence of new staff. The provider had investigated this and acknowledged that the introduction of new staff had unsettled people. They told us they now planned to introduce new staff to people in a 'gradual and sensitive' manner, to enable them to become familiar with 'new faces'. They went on to say since our inspection visit, the service now supported only two people and one person's behaviour had started to show signs of improvement.

Staff had completed training in safeguarding people and knew what action they would take if they had any concerns about people. All the staff we spoke with had a good understanding of abuse and how to keep people safe. They knew there were safeguarding policies to guide them and the process to follow to report any safeguarding concerns. One staff member told us, "Abuse can be physical, verbal and emotional. I would tell the manager and if I wasn't happy I would also tell the police or you the CQC."
Despite staff telling us during our inspection visit they felt able to raise safeguarding concerns with the manager, information we received following our visit suggested some staff did not feel supported to raise concerns or 'whistle blow' (anonymously report concerns). We spoke with the provider who told us there was no evidence to support this allegation. They told us the manager had discussed safeguarding at a recent team meeting and had informed staff they could speak to the manager, provider's Operations Director or Quality Improvement Lead, if they had any concerns that people were not safe. Staff were also reminded they could use the provider's internal 'whistle blowing' telephone line. The provider added that staff meetings were now going to be held monthly during which staff would be reminded how to report safeguarding matters.

The provider's recruitment policy and procedures minimised risks to people's safety and ensured only suitable staff were employed. Prior to staff working at the service, the provider checked prospective staff member's suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to start working at the service until checks had been received from the DBS and reference requests had been returned.

Following our inspection visit we received information that certain members of staff had used rude and inappropriate language and 'bullied' staff and people living at the home. It was also alleged some staff were using their own mobile phones whilst supporting people and allowing unauthorised visitors into the home. This had been investigated by the provider who informed us there had been no reports of people being shouted at or bullied. They acknowledged there had been some staffing issues, robust action had been taken and the staff involved were no longer employed at the service. All remaining staff were reminded about the use of personal mobile phones whilst on duty and not to allow unauthorised visitors to the home. In addition, training was to be provided to staff to remind them of the importance of respecting people's privacy and dignity.

The provider carried out safety checks of the service and we saw there were up to date emergency folders containing all relevant information that would be required in an emergency situation such as a fire. These documented people's care and support needs so they could be assisted safely.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with thought most staff had the skills and knowledge to care for their family members effectively. However they felt the use of agency, and new staff, who did not know people well was unsettling for people living at the home and increased their anxiety levels. One commented, "Some agency staff don't always appear confident in managing challenging behaviours."

The Quality Lead told us they tried to use regular agency staff who had the necessary skills to support people with challenging behaviour. They acknowledged however, the permanent staff were best placed to support people as they knew them and their behaviours well. As new staff were being recruited the use of agency staff was reducing.

Staff received training suitable to support people with their health and social care needs. This included 'Proact Scip' training so staff could support people who had behaviours that could place themselves, or others, at risk of harm. The aim of this training is to minimise the use of physical intervention and to use de-escalation techniques to reduce a person's anxiety.

On occasions, to keep people safe, restraint was used by staff who were trained to carry this out safely. We had been informed by the provider before our inspection visit, that one incident resulted in a person being restrained for varying periods over 40 minutes. A best interest decision had been made and agreed, when necessary to protect the person from harm, this type of support was required. During our visit, the manager informed us this had not been continual restraint and the person was allowed to sit up at several points, but became agitated again. They assured us this was only carried out to prevent injury to the person, and others, and de-escalation techniques had not been successful.

However, following our inspection visit, the provider informed us that an incident had occurred where a person had been restrained on the floor. Some staff had not followed correct guidelines and this had resulted in excess pressure being applied to the person's shoulder which may have caused them pain and discomfort.

We had also received information from a member of the public that alleged restraint was being used by staff, when it was not necessary or in an appropriate way. These concerns were still under investigation by the local safeguarding team at the time of our report and the provider now instructed staff that 'floor hold' restraints were no longer to be used. In addition all staff would be required to undertake a refresher course in 'Proact Scip' training.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13. Safeguarding services users from abuse and improper treatment.

During our inspection visit the provider's Positive Behavioural Support Practitioner told us, "I don't think all staff are confident, but I am addressing that. Using 'hold down' does not really sit comfortably with me." They explained all the staff were to have three days of intense training to increase their skill level to give

them the competency and confidence to manage situations with the minimum of physical intervention.

Although some training had been scheduled, when we carried out our inspection visit, records showed not all staff had attended. The Positive Behavioural Support Practitioner told us they had arranged a training session for staff about effective communication with people but no one attended. They told us, "I am trying to engage with the staff and provide training but it's a work in progress. It's a bit frustrating." We discussed this with the manager who agreed attendance for staff training needed to be improved and some training for staff still need to be completed. The training schedule was being updated to ensure all staff had completed the necessary training. Following our inspection visit the manager sent us a copy of the updated training schedule. This outlined training that had been completed and scheduled dates for each staff member to undertake the required training.

We asked staff if they felt they received enough training to enable them to carry out their role effectively. The deputy manager told us, "I have had training and I am confident to manage behaviours but people are unpredictable and very strong. I don't think all staff are confident to use training techniques but further training is going to be provided." Other staff we spoke with told us they felt the training they received was effective.

The provider told us in response to the concerns raised after our visit further training would be provided to staff to increase their confidence when supporting people. They said, this would include Autism, effective communication, Positive Behavioural Support, and person centred care.

The provider had enrolled new staff on the Care Certificate Course. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people. Staff new to the home told us they completed an induction programme and 'shadowed' an experienced member of staff before they supported people independently.

Staff told us during our inspection visit, they felt supported by the management team with regular one to one meetings. This provided them with the opportunity to discuss their work performance and learning and development needs. One staff member told us, "I had my supervision yesterday, so yes, we get them. We talked about me, people at the home and my career."

However, information we received following our inspection visit suggested some staff did not feel comfortable raising matters with certain members of the management team during supervision meetings. The provider was investigating these concerns. They also acknowledged staff supervisions were not being consistently carried out and this was being addressed. All outstanding supervisions were to be completed by the end of October 2017 and moving forward would be held with staff every eight weeks.

Staff mostly had a working knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what it meant for people. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We looked a people's care plans and saw best interest decisions had been made. For example, one person was unable to take their medicines on their own. A best interest meeting had taken place with the family and healthcare professionals and a decision made that staff would be responsible for giving the person their

medicines. A relative we spoke with confirmed they had been involved in making decisions for their family member when needed.

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. All the people living at the home had a DoLS in place because restrictions on their liberty had been identified.
After our visit we were informed one person, had their door held a jar to by 30 cm to prevent them from leaving their room. This restriction was outside of their DoLS authorisation and meant the person's freedom was being restricted without the required authorisation. This was under investigation by the local safeguarding team.

We discussed this with the provider who told us the restrictive practice had been put in place because the person was throwing items around their room and their behaviour may have caused harm to staff who were observing the person throughout. They told us a review of the person's support plan and medication would take place to help reduce their behaviours and their DoLS would be reassessed if further incidents reoccurred. Plans were also being considered to move the person to a room on the ground floor to avoid the use of stairs when they became anxious. This meant staff could keep the person and themselves safe, when they displayed challenging behaviours.

Staff understood issues around people's capacity to make certain decisions and why DoLS authorisations were in place for people. Staff told us they had received training around the MCA. They told us, "It's all about people being able to make their own decisions and how we support that." Another said, "Some people refuse care or their medicines, I respect that and try again later. Sometimes I ask another member of staff as a different face can work."

People who lived at Autumn Leaf House were involved in choosing their own meals with support from staff. Some people required special assistance with their meals. For example food that could be mashed to reduce the risk of choking or food cut into smaller pieces so it could be chewed easily. One person's diet needed to be carefully monitored in order to maintain their health and well-being and we saw staff were recording how much they had to eat and drink.

Where appropriate, specialist support and advice had been sought and support plans put in place to guide staff on how best to support people with their food and fluid intake. Each person had a support plan that identified their health needs and the support they required to maintain their emotional and physical well-being. This helped staff ensure that people had access to the relevant health and social care professionals.

We asked relatives if their family members had access to healthcare when they needed it. They told us, "Yes, there is no issue with that. If [person] needs the doctor they will sort it out." Another said of the staff, "They take [person] to appointments which I know can prove difficult. They do seem to care about [persons] health."

Records showed people were supported to attend health appointments and received care and treatment from health care professionals when required, for example dentists and occupational therapists. During our inspection visit staff supported one person to a routine hospital appointment.

Requires Improvement

Is the service caring?

Our findings

Relatives told us they thought staff were kind and caring. They commented, "They are good and I can't fault them. I can see [person] likes them." And, "The staff seem so caring and they do speak to [person] kindly which reassures me [person] is well looked after."

During our visit we spent some time observing the interactions between staff and people. There was a friendly and relaxed atmosphere at the home and we observed people were comfortable approaching and engaging with staff. Most people appeared accepting for us to be in the home however, we were aware that our presence was unsettling to other people. Staff alerted us when they felt people were becoming anxious and asked us to move to different parts of the home.

One person asked to speak with us and they took our hand and showed us around their flat. They held our hand and laughed with us, and the staff members present. It was clear they had formed close relationships with the staff. Staff spoke affectionately about people, and were clearly committed to provide quality care and support.

We heard staff speaking kindly to people and heard one telling a person, "Tell me what that song is you like to dance to." The person showed us a music CD and then played their favourite song. We saw them laughing and dancing with staff and when they had finished they hugged the staff member.

However, following our inspection visit we received information of concern that one staff member 'demanded' that people living at the home hugged and kissed them, despite one person indicating they did not wish this. The provider investigated this and told us there was some evidence to suggest this was true and would be dealt with under their performance and staff conduct process.

Staff supported people to maintain their independence by doing things for themselves. A relative told us staff supported their family member to be as independent as possible, for example tidying up and shopping. A member of staff said, "We encourage independence as much as possible." They explained how one person liked to help make their own meals with assistance. During our visit the person wanted beans on toast for their lunch. We heard staff asking them to help and one senior care worker explained, "Staff will prepare some of the meal, but [person] likes to put their toast in."

Staff had a good understanding of the importance of respecting people's privacy and dignity. We observed they knocked on doors before entering and care plans indicated to staff when they needed to give people additional privacy, for example, when they were having a bath. One person liked to eat their meals in private and records informed staff they needed to respect this, but remain close by if the person needed assistance.

People's rooms provided them with their own private space, and where possible they had been supported to choose how their rooms were decorated and furnished. We saw people had their own personal possessions and decorations. For example, one person liked cushions and soft toys and we saw several in

their room. We also saw their walls were decorated with pictures they had helped make.

There was a communal lounge that people could use and during our inspection we saw people coming and going as they wanted around the home.

People were able, where possible, to make choices about how they spent their day and we saw that people got up and had their breakfast when they wanted. A relative we spoke with told us, "[Person] does get offered choice." Staff told us they supported people to choose what they wanted to wear and how they wanted to spend their day.

We asked how they were able to give people who had limited communication, the option to choose. One told us, "[Person] can't cope with too many choices so I give just a couple and they can make choices that way. For example, two items of clothing or two meal options." They went on to describe how they also used picture cards of different foods and communicated with Makaton sign language. (Makaton is a language programme using signs and symbols to help people to communicate.)

However one relative told us they were concerned some staff who were unfamiliar with their relative, would not always be able to understand their needs. For example, they had been concerned their family member's hair was not washed on occasions. They had discussed this with staff who told them the person did not want their hair washing. The relative told us, "It could be because the staff are new and just don't know [person] well enough. I have to explain to them how to encourage [person]."

Relatives we spoke with confirmed they were involved in making decisions about their family member's care. They told us they were able to sit and discuss their family member's care with staff. One told us, "I do feel involved, I have been asked to contribute to the care plan. I have read it and it is all about [person]."

Requires Improvement

Is the service responsive?

Our findings

People living at Autumn Leaf House were each allocated a staff member known as a 'keyworker', who got to know their likes, dislikes and with whom they could build a relationship. However due to the high staff turnover these had not always been consistent. One relative we spoke with told us, "[Person] gets confused with all the staff changes and this makes them frustrated and affects their behaviour."

The manager told us where possible staff were allocated to work with one person to provide continuity of support; however it was important all staff had a good understanding of everyone in the home and their needs.

Each person had a detailed support plan so staff could read and understand each person's individual preferences. Support plans contained up to date and detailed information for staff to provide appropriate levels of care and support to people including activities outside the home. Plans were individualised and informed staff what people liked and how people wanted their support delivered. Plans contained a section called "About me" which gave detailed information on people's likes and dislikes and what triggers may affect their behaviour.

We saw one person's care plan informed staff what type of shampoo they liked to use and their preference of body lotion. Another person's records told staff they preferred their bath before eating their breakfast. To help the person manage their routine and provide structure to their day staff were reminded to break the day up into 'now and next' activities. We saw the person had a chart in their room that showed them what activities they would be doing next, for example helping to prepare lunch or visiting a local park.

The support plans were person centred which means they were based on each person's individual needs and the support they required. Relatives we spoke with told us staff would discuss their family member's care with them. They told us, "[Person] likes looking in the mirror. I told the staff this and they bought one, which was good."

We saw that the support plans were reviewed regularly and people were involved as much as possible in the review of their care and support. One relative told us, "I have meetings with the staff and we talk on the phone if anything happens." Relatives told us they were able to discuss any issues or concerns with staff when they visited the home

We saw that staff were knowledgeable about the people they supported, Staff told us, "When I started here I read everyone's care plans. After that I felt I knew them all as individuals. " Another member of staff told us, "Care plans and risk assessments are really detailed and I help to write them because I know people well, all the important information gets added."

Due to some people living at the home having limited verbal communication, staff told us they used body language, facial expressions and gestures as guides to identify how people were feeling. We observed that

staff quickly identified when people wanted something. One staff member told us they were able to identify when one person was becoming anxious as they would bite their own hand. They told us, "I sing to them because [person] loves that." During our inspection we heard staff singing to the person as they were encouraging them to attend a hospital appointment. The person was anxious about getting into the car and we heard staff were patient and took their time until the person felt confident enough to get in.

Staff were responsive to changes in people's needs. There was a daily handover with relevant communication regarding each person and any areas of concern. One staff member told us, "Communication is brilliant amongst the staff. We have a daily log which gives us information about what might be working well for someone and what activities they have been involved in that day." The manager told us it was essential that staff were always fully up to date regarding people living at the home and the support they required.

Shortly after our inspection visit two people, on short term placements, moved to new providers of care. The manager told us to ensure smooth transitions for people between services; staff would liaise with all the healthcare professionals involved in the person's care. Staff from the new provider would visit the home and meet the person, and their relatives. This would assist the new provider in deciding which members of staff at the new home would be best placed to support the person and to understand their needs and ensure consistency of care.

A transition was underway for another person and the manager told us the person had become anxious on meeting the new provider's staff. They told us they would continue to liaise with the new provider, but felt the presence of unfamiliar staff was causing the person to be unsettled.

However we spoke to a social worker who supported one person who moved out of the home shortly after our inspection visit. They told us they did not feel the provider at Autumn Leaf House had communicated sufficiently with them at times about the person's progress at the home. This had impacted on the transition process which had not been as smooth as it could have been for the person involved.

People were supported to pursue some individual hobbies and interests, however relatives told us they were concerned people were not accessing activities as much as they had previously. One told us, "I think the activities have reduced recently, I don't know if it's because of the changes in staff." Another told us they were concerned their family member had lost confidence in accessing the community and this had impacted on them visiting their family at home. They suspected this was because their family member had been affected by challenging behaviours of others living at the home which had unsettled them.

After our inspection visit we received further concerns about the availability of meaningful activities for people and staff engagement during these. We were told some staff did not interact with people and chose activities which they enjoyed and not those based on people's hobbies and interests. We shared these concerns with the provider. They told us people's activity planners would be 'reviewed and improved' to offer more activities based around their individual likes and dislikes. In addition one person's family would receive a weekly update on what activities their family member had been involved in. Plans were also in place to produce photographs of activities undertaken by people, which could be shared with their families.

We spoke to the Quality Lead during our inspection visit about the relatives comments and they told us, "We have been concerned about [people's names] and that sometimes things can be overwhelming for them. We want to improve their experience." They told us they were confident, as people left the service, that more focus could be placed on activities and support for people remaining at the home.

The manager told us, "I don't think the activity programmes are structured enough so we want to improve that." They went on to say they were looking to create a sensory room for people and quotes were being obtained for the back garden to have artificial turf laid. We saw a vegetable patch in the garden for people to enjoy. The manager told us people had been assessed by an occupational therapist to look at ways to provide sensory stimulation, for example using a firm brush on a person's skin.

All the staff we spoke with stressed the importance of trying new activities with people and involving them in the local community. A member of staff told us, "We will be looking at new activities for people and develop a plan for each person. We will include everyone in this. It will be good to have 'fresh eyes' from new staff for their suggestions and we will include people and their families."

The provider had not received any formal complaints; however, relatives told us they usually spoke with staff in the first instance if they had any problems. One told us, "I have meetings with the staff and we talk on the phone if anything happens.

Requires Improvement

Is the service well-led?

Our findings

The service had not been consistently well led. Since registering with us in September 2016 the provider had experienced three changes in the service manager and a restructuring of their services. This had led to inconsistent management of the service and senior managerial oversight. The service did not have a registered manager. A new manager started work six weeks before our inspection visit and was planning to register with us. However, the provider recently informed us they were no longer employed at the service and another interim manager was now in post.

There had been a high turnover of staff and staff told us supporting some people, who displayed high levels of challenging behaviour, had been extremely stressful. At times staff told us they had not felt sufficiently supported by the provider. The lack of a consistent manager, and senior managerial oversight, had left staff feeling unsettled. Some spoke of feeling anxious and one told us they had considered leaving the service. Other staff told us they believed the lack of managerial support by the provider had led to several staff leaving.

Following our inspection visit we received information of concern that alleged the management had not acted on reports from staff regarding the conduct of certain members of staff, despite written statements being provided and requests for equipment. The provider informed us they had conducted an internal investigation into all the allegations and the staff members involved were no longer employed at the service. In addition the manager was to receive additional, on-going support from senior managers. Allegations that the equipment had not been ordered was still under investigation by the provider as the clinical need for this was unclear.

The provider's Quality Lead acknowledged the home had experienced considerable changes and had at times been unstable. They told us, "We have had lots of manager changes and it hasn't helped the home, people living here and staff."

Systems and processes to assess, monitor and improve the quality and safety of the service were not always effective. At times people were not supported safely and although some audits had been carried out, they had not identified some areas of concern in a timely manner, for example missed medications. The provider had not consistently ensured that people were supported by staff who had the necessary skills or confidence to support people. In addition the provider had not ensured risk management plans to keep people safe were consistently followed.

The provider had not consistently communicated with other professionals to ensure a smooth transition between services and some relatives felt there was a lack of communication about important matters such as changes in the manager.

Incidents and accidents had not been consistently analysed to identify trends. The manager told us there was a backlog of forms that were being reviewed. This meant opportunities to identify a pattern of behaviour for a person, such as the time of day or after a particular event, may have been missed. For

example, one person responded negatively to the introduction of new staff to the home. Constant staff changes had increased anxiety and challenging behaviours for some people. This in turn had impacted on the quality of the service other people were receiving and their health and well-being.

Relatives told us they felt the constant changes had affected their family member's anxiety levels and behaviours. One told us, "There have been lots of manager changes; I hope the manager stays, as [person] needs consistent staff." Another told us they had not been informed one manager had left the home. "I needed to know that and I was unhappy I wasn't told."

The provider's management team were open and transparent about the difficulties the home had experienced. The Director of Quality told us, "The lack of robust leadership meant the home didn't get consistent direction."

This was a breach of Regulation 17 HSCA RA Regulations 2014. Good governance.

Staff we spoke with were positive about the new manager, but told us they had felt unsettled with the constant managerial changes. One said, "Management changes haven't helped because it unsettled the service users and the staff. Leadership has been a bit inconsistent. I see light at the end of the tunnel though, and I think things will improve."

Moving forward, the Quality Lead told us that as people left the service, no new admissions would be accepted, which would allow the service time to stabilise. They told us, "We need to rebuild the service. The senior managers have agreed that safety comes first and always will do." The provider's quality team visited the service daily to provide support and staff told us they now felt well supported by the provider. Following the new information of concern we had received, senior members of the providers management team had been working at the service to ensure the safety and wellbeing of people.

A robust action plan was in place following a comprehensive quality audit of the service conducted by the provider. This detailed improvements that were required with dates for completion. For example, medication audits, ensuring staff training was up to date and the evaluations of care plans needing to be more comprehensive. The manager told us they had contacted family members to introduce themselves and plans were in place to invite families in to discuss their family members care and support.

Although we had received information, following our inspection visit, to suggest some staff were unhappy, other staff told us during our visit they were happy working at the home and enjoyed their job. Staff had formal team meetings and one to one supervision meetings. These provided opportunities for staff to raise any concerns or issues they had with their manager and the provider. The provider acknowledged that supervisions needed to be held more regularly and these had been planned.

The provider understood their responsibilities and the requirements of their registration. They were able to tell us what notifications they were required to send us, such as changes in management, safeguarding and serious injuries. A statutory notification is information about important events which the provider is required to send to us by law. Whilst the provider understood the requirements of their registration we found these had not always been met. For example, we had not received notifications to inform us of missing medicines or a safeguarding. The provider acknowledged this was an oversight.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) The provider did not ensure care and treatment was provided in a safe way for service users. 12 (2) (b) The provider did not do all that is reasonably practicable to mitigate risks to people.

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 13 (4)(b) The provider did not ensure acts intended to control or restrain a service user that are not necessary to prevent, or are not a proportionate response, to a risk of harm were used correctly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) The provider did not continually assess, monitor and improve the quality and safety of the service. 17 (2) (b) The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.