Mr & Mrs L Alexander

Park Avenue Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 3 and 4 November 2015 and was unannounced.

Park Avenue Residential Home is registered to provide residential care without nursing for up to 25 younger people with a mental health diagnosis. The service is comprised of two Victorian houses number 74 and number 76, each house accommodates a mix of male and females and has shared bathroom facilities. The two houses are not joined but have communal access to gardens and a shared parking area at the rear of the properties. People are able to move freely between the two houses. At the time of the inspection there were 21 people living at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Summary of findings

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The service had 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.

Staff did not always demonstrate that they had the required knowledge to be able to safeguard people and report all concerns to the relevant safeguarding authority. Staff had been trained in how to identify and report safeguarding situations. However one incident had not been reported to safeguarding as the person it concerned did not want it reported. Staff had not understood they could override a person's choice if there was a significant risk to themselves or other people as a result of not reporting concerns. Although action had been taken to safeguard other individuals living at the location following incidents, there had been a failure to review safeguarding incidents at an overarching service level. This was required in order to identify any themes or further action required across the service to keep all people safe from the risk of abuse. As a result people subsequently alleged they had been abused by other people within the service.

People were not always supported by staff who had been provided with sufficient information to be able to meet their needs safely. The pre-admission process was not sufficiently robust to ensure decisions to admit people were always based on the full range of information available. The provider had not always taken into account people's personal histories when deciding whether they could safely accommodate people and manage the potential risks to them or others. People's risk assessments were not always thorough to ensure risks to them and others were managed safely. This had led to people experiencing harm.

Records showed that there were not enough staff employed to ensure the staffing roster based on the historical staffing level for the service was always fully covered. There were not always enough staff to ensure there could be two waking night staff one for each house at night to ensure people's safety. There were insufficient staff to ensure that people's needs were being met safely. People, a community psychiatric nurse and two social workers told us there were not always enough staff. People told us there were not always enough staff at weekends to support them to participate in meaningful activities. Records also showed that there were not enough senior staff employed to ensure there were always senior staff deployed on each shift to provide advice, guidance and support to staff. There were not sufficient staff employed or deployed to meet people's needs safely.

Medicines were not always managed safely. Some prescription medicines are controlled under the Misuse of Drugs Act 1971; these medicines are called controlled drugs or medicines. The provider had not ensured that robust records had been kept for controlled drugs. Medicine audits had been completed but there was a lack of related action planning to manage the risk of reoccurrence. People had medicine risk assessments in place. However, these did not always take into account the risks medicines could pose to individuals and ensure identified risks were managed safely. Procedures for the administration of 'When required' medicines did not ensure clear, sufficient information was available for people to take them correctly and consistently in response to their individual needs. When required medicines are those which are not consistently used by people and can include pain relief medication.

People did not always receive food which had been stored appropriately. Staff had not always fully followed food safety guidance to ensure people's food was handled safely and the risk of bacterial growth minimised.

Staff had undergone an induction to their role and were supervised in their work. However, people living at the location had diverse and complex mental health diagnoses. Some had a secondary diagnosis of a learning disability or a personality disorder. Other people had a forensic history, this is when a person with a mental health issue has been arrested, is on remand or has been

Summary of findings

to court and found guilty of a crime. A staff member told us they had requested additional training in forensics but this had not been arranged. Other people had a history of drug or alcohol misuse. Not all staff had received relevant training in relation to mental health, personality disorder, drug and alcohol misuse, forensics and learning disabilities to enable them to meet people's needs effectively.

People were subject to restrictions upon their movements, such as the times they could access the kitchen, the fridges were locked and people could not watch the communal televisions before 17:00. Although these did not amount to people being deprived of their liberty. There were generalised practices in place which were not underpinned by robust risk assessments to demonstrate either why they were required or that people had been consulted about their use.

People provided negative feedback about the quality of the meals provided. People had to choose their meals five weeks in advance rather on the day or the day before which would have enabled them to make meaningful choices. The meals served to people did not take into account their dietary needs or preferences regarding portion size to ensure they received an appropriate amount of the right type of foods to meet their nutritional needs.

The provider had not always considered how practices within the service impacted upon people's rights to privacy and dignity. People were accommodated within mixed sex accommodation with shared access to bathroom facilities. People's need for privacy and dignity had not always been met.

The processes for auditing the quality of the service had not been effective. Audits had been completed in October and December 2014 but no action had been taken until they were provided to the registered manager on 28 July 2015. The audits had not identified the issues found at this inspection.

People's records were not complete and contained insufficient information to demonstrate how decisions to admit people had been reached and their suitability for the placement. Some people's care plans contained insufficient information for staff about the support they required and how this was to be provided.

There was a lack of a clear documented vision of the service in terms of who they accommodated and the type of service offered. The provider had admitted people with very diverse needs which made it challenging for staff to safely and effectively meet everyone's needs. The provider's values had not been consistently applied within the service as a result risks to people had not always been managed.

People told us staff supported them to see healthcare professionals as required.

People told us they were involved in planning their care. The registered manager had just introduced weekly keyworker meetings to support people with weekly goal setting. However people's records did not always fully document people's involvement in their care planning.

People's needs had been assessed and re-assessed and where possible people had been supported to develop their independence with a view to moving to other more independent living accommodation. Staff supported people to measure their recovery and to develop crisis plans. People were supported to access a range of community activities. Although there was a structured programme of activities people told us they did not always receive sufficient stimulation at the weekends.

Resident's meetings had been held, however these were led by staff and people did not have full control of the meeting or the agenda to ensure it was fully run by them and reflected their priorities.

Feedback regarding management and leadership was positive. However, for the size of the service and the complexity of people's needs there was insufficient management time allocated to address all of the issues within the service. The registered manager had only received a minimal amount of formal supervision from the provider to support them in their role.

The service worked with a range of other services for the provision of people's care. However, the provider had not always received a consistent level of support from mental health services in order to ensure people's changing needs could always be met.

Summary of findings

Most staff had undergone training in the Mental Capacity Act 2005. Where staff had identified people lacked the capacity to make a specific decision about their care they had made arrangements for the person to receive an assessment of their mental capacity.

Staff had undergone relevant pre-employment checks to ensure they were of good character and suitable to work with people.

People we spoke with all gave positive feedback about their relationships with staff. People told us staff were good to them and supportive. People benefited from continuity of staffing and staff understood their care needs.

People had been provided with information about their rights within the service. People's permission was sought before information was shared about them. People were consulted about the content of the fortnightly activity schedule and asked for their ideas for activities.

Processes were in place to enable people to make a complaint about their care if they wished. Complaints had been investigated and responded to appropriately.

During the inspection, we identified a number of serious concerns about the safety and welfare of people who received care from the provider. We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

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 had not been adequately protected from the risk of abuse and people alleged they had experienced abuse from other people.

Risks to people were not always managed to ensure people were kept safe from harm.

There were not always sufficient numbers of suitable staff to keep people safe and to meet their needs.

People's medicines had not always been managed safely.

Staff had not always fully followed food safety guidance to ensure people's food was handled and stored safely.

Is the service effective?

Inadequate

The service was not effective.

People were receiving care from staff, some of whom had not all had the training they required in order to carry out their role effectively.

People were having their movements restricted by working practices that were not underpinned by appropriate risk assessments. People were not consulted about these practices.

People told us they did not enjoy their meals. People's meal choices were requested five weeks in advance and people's dietary needs were not take into account when the meal was served.

Where people lacked the capacity to consent to their care legal requirements had been met.

People were supported by staff to access healthcare services.

Is the service caring?

Requires improvement

The service was not always caring.

People's privacy and dignity had not always been respected and promoted, due to practices within the service and the shared bathroom facilities.

Staff had developed positive caring relationships with people who used the service.

Summary of findings

People were made aware of their rights and their permission was sought before information was shared about them. People were consulted about activities within the service.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's involvement in planning their care had not always been evidenced.

People were supported to attend a range of activities to support their re-enablement to become more independent. However, there were limited opportunities for people to be involved in meaningful activities at the weekends.

People were not empowered to organise and run the resident's meeting themselves.

The service had a complaints policy for people and their relatives to make a complaint if required. People told us they knew how to complain.

Is the service well-led?

Requires improvement

The service was not always well-led.

Staff had not always implemented the provider's values in their work with people. Not all staff experienced a good level of morale working at the service.

Processes in place to audit the quality of the service were not sufficiently robust or effective at driving service improvement. Audits of the service had been completed but had not been acted upon in a timely manner in order to drive improvements to the service.

People's records were not complete and contained insufficient information about their care needs to enable staff to provide the appropriate and necessary care.

There was lack of written clarity about who the service was to be provided to and what care could be provided, to enable people and commissioners to make informed decisions about whether the service could meet people's needs.

Feedback regarding management was positive. However, there was a lack of management time to fully address the issues within the service. The service people received had been negatively impacted upon as there was insufficient management time to monitor the service and to drive improvement.

Summary of findings

The provider was keen to work in partnership with other agencies. However difficulties had been experienced when trying to access support from mental health services for some people in their care.

Park Avenue Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 3 and 4 November 2015 and was unannounced. The inspection team included two inspectors, two pharmacists and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of using mental health services.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. We used this information to help us decide what areas to focus on during our inspection. We did not request a Provider Information Return (PIR) from this provider prior to the inspection. This is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make.

Prior to the inspection we spoke with a person's social worker. During the inspection we spoke with eight people. We spoke with the registered manager, the deputy manager, the activities co-ordinator, the Wellness Recovery Action Plan (WRAP) co-ordinator and three support workers. Following the inspection we spoke with a safeguarding chair from the local authority, a community psychiatric nurse, two social workers and commissioners of the service.

We reviewed records which included eight people's care plans and people's medicine records. We observed the lunch service, a resident's meeting, a cooking activity and a staff handover. We reviewed three staff recruitment and supervision records and records relating to the management of the service. We reviewed staffing rosters for the period 23 August to 7 November 2015.

The service was last inspected in February 2014 and no concerns were identified.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe in the service. However, records demonstrated people had not been adequately safeguarded either from the risk of experiencing abuse or from the risk of further abuse.

A person disclosed to us during the inspection that they had been abused and this was reported to the registered manager who then reported the incident to the relevant authorities. However, there had been one incident that had not been reported to the local authority as a safeguarding incident as the person had not wanted it to be reported. Action had not been taken and an opportunity had been missed to safeguard this person from further abuse. Although all staff had undergone safeguarding training. They had not understood that where there is coercion or a significant risk to the person this must still be reported as a safeguarding incident to the local safeguarding authority.

When safeguarding incidents had occurred, other than the previously mentioned incident, the registered manager had taken action in response to the incident to safeguard the person and put plans in place to reduce the risk of that person experiencing further abuse. However, there had been a failure to review the outcomes of safeguarding incidents at a location level and to fully evaluate the potential future risks to others. There had been a failure to consider whether any work was required with people whom allegations had been made against to reduce the risk of them abusing people again. People alleged they had been abused by other people accommodated within the service.

The failure to ensure people were protected from abuse, to operate effective systems to prevent the abuse of people and to act upon an allegation was a breach of Regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's pre-admission processes and records of assessment were not sufficiently detailed or robust to ensure decisions about whether to admit people had always been made soundly, taking full account of the information available to the provider, about the potential risks people could present to themselves or others. Information had been provided during a person's pre-admission assessment about their previous risk history; however, the provider had failed to fully evaluate this when deciding upon the suitability of the placement for them. This had placed people at risk of harm. Another person was placed within the service without sufficient consideration being given to their personal history and whether potential risks to them from others and from their behaviours could be managed safely within the service. The decision to accommodate them had resulted in them alleging they had experienced harm.

There was evidence that a person with a forensic history had a thorough risk assessment. This clearly identified their potential risks and how they were to be managed. A forensic history is when a person with a mental health issue has been arrested, is on remand or has been to court and found guilty of a crime; However, other people's risk assessments were not sufficiently detailed or robust enough to safely manage identified risks to them or others.

The failure to fully take into account information about people's risks prior to deciding to accommodate them and the failure to effectively manage identified risks to people and to others was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were not always enough staff. One person said 'It's okay ... we need more at weekends.' People said there was nothing to do at weekends and, with more staff, that would change. The community psychiatric nurse and two social workers told us they had concerns about staffing levels at the service. People and professionals felt staffing levels were not always adequate to be able to meet people's needs safely

The provider did not use a staffing tool to assess the required level of staffing. Staff told us there were three staffing shifts per day. 07:30-14:30, 14:00-21:00 and 20:45 to 07:45. There were two care staff on each shift. During weekdays there was also an activities co-ordinator from 10:00 until 16:00 on four days and the provider's Wellness Recovery Action Plan (WRAP) worker, worked with people on two days of the week. The staffing rosters showed there were insufficient staff to meet the provider's rostered staffing. There were not sufficient staff employed to ensure they could be scheduled to cover the additional one to one hours support rostered for people on 27 occasions between the period of 23 August 2015 and 24 October 2015.

The registered manager told us the service should have had two waking staff at night. However, if they were unable

to provide these staff due to sickness or annual leave then a member of the day staff would sleep in. Records demonstrated there were insufficient staff to cover the waking nights on 21 occasions between the period of 23 August 2015 and 24 October 2015. Staff told us two people had audible alarms on their bedroom doors to alert them if their bedroom doors were opened at night. We checked one of the alarms and it could not be heard from the staff sleep-in room. This meant if people's alarm sounded there was a risk staff would not have been alerted and checked why it had sounded.

The registered manager told us if there was a sleeping staff member then people needed to use the house pay phone to ring staff in the opposite house if required. This did not take into account whether the person was physically able to request help. The additional one to one hours support for people scheduled on the staffing roster had not always been provided for people as required.

There was a lack of sufficient staff to always cover day time activities at weekends. There were nine weekend days between the period of 23 August 2015 and 24 October 2015 when there were only two staff on duty to provide people's care and no additional staffing support arranged to cover daytime activities.

There were insufficient staff to cover staff leave and sickness. If domestic staff were on leave there were no additional staff available to cover their hours and complete their role. For the number and complexity of people's needs, there were only two staff on duty after 17:00 once the registered manager had finished work. If a person experienced a crisis or needed additional assistance this left one member of staff to care for all of the other people living at the location. Staff told us there was insufficient time to cook for people with the numbers of staff working and available Monday to Thursday. There was only one senior support worker; this was not sufficient to ensure there was adequate senior staff cover on all shifts. There was not always a senior member of staff on shift after 17:00 and there were no senior night staff, to lead the staff shift. There were insufficient staff employed and deployed to meet people's needs safely.

The provider did not have a process in place to determine the required staffing level to meet people' needs safely. There were insufficient staff employed to cover the staff roster at all times. There were insufficient staff rostered at all times to meet people's needs safely. These were breaches of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records confirmed they had undergone recruitment checks before working for the service. These included the provision of suitable references, employment history, proof of identity and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff had undergone relevant pre-employment checks to ensure they were of good character and suitable for the role.

Medicines were stored in locked cabinets. The room temperature where medicines were stored had been checked regularly and recorded to ensure it did not exceed recommended safe levels. The service had appropriate arrangements for obtaining medicines. Staff were seen to safely administer people's medicines. Unused medicines were returned to the pharmacist for safe disposal.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971; these medicines are called controlled drugs or medicines. Appropriate storage was in place for controlled drugs. However there was not a suitable controlled drugs register in use to ensure records related to these drugs met legal requirements. There was no clear process for including correspondence and changes to people's medicines care plans, following medical advice. Such as verbal instructions from healthcare professionals, to ensure that complete and accurate records were kept for each person. There was insufficient information available for people prescribed 'When required' medicines to enable them to take them correctly and consistently in response to their individual needs. When required medicines are those which are not consistently used by people and can include pain killers.

Medicine audit tools were used to ensure people were kept safe from the risks associated with medicines. Records of two incidents involving medicines, demonstrated they had been appropriately managed. However, there was a lack of action planning in place following audits and medicines incidents to prevent further incidents occurring.

People had all been assessed using a medicines needs assessment form and offered varying amounts of support

Inadequate

Is the service safe?

from staff with managing their medicines. However, people's risk assessments had not always taken into consideration the risks medicines could pose to them as individuals. For example, potential risks posed by medicines storage. People who had been supplied with medicines for later self-administration had not always had these appropriately labelled to ensure they knew what medicines were which. People had not always been kept safe from the risks associated with medicines.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On four days of the week people's meals were provided from another location. The food arrived in insulated containers and the temperature of the food was taken upon arrival to ensure it met food safety requirements. Staff were observed on the first day of the inspection to serve people's meals without wearing protective equipment such as a blue plastic apron or gloves which meant food was at risk of being contaminated. Staff covered seven people's meals with cling film to protect the food before it was later placed in the fridge, however, it was still warm, which risked bacterial growth. Fridges in the kitchens were kept locked and although staff could return the milk to the fridges when not in use, staff left it out on the countertop for peoples' use. This was not in accordance with good food hygiene practice.

Inadequate

Is the service effective?

Our findings

People had a diverse range of mental health diagnoses and needs with which they required support. Some people also had additional needs related to a learning disability, personality disorder or forensic history. This is when a person with a mental health issue has been arrested is on remand or has been to court and found guilty of a crime. Other people had a history of drug and alcohol use.

Staff told us they had received an induction to their role and regular supervision of their work, which records confirmed. Training records demonstrated that out of the 13 frontline staff employed three had undertaken a professional qualification in mental health. A further two had completed mental health awareness training. The remaining eight staff, including the registered manager, had not completed mental health training. This training would have provided staff with an understanding of mental health issues, diagnoses and enabled them to offer appropriate interventions to make them more effective in their role. Although some people living at Park Avenue Residential Home had a diagnosis of a learning disability no staff apart from the registered manager had undergone training in this area.

Some people had a diagnosis of an emotionally unstable personality disorder. People who are diagnosed with this disorder may be chaotic, impulsive, struggle to manage their emotions and harm themselves. Only one staff member had received any training in this area to enable them to understand the behaviours people might exhibit, especially when experiencing a crisis, and how to support them appropriately. The registered manager told us one person had experienced behaviours which challenged staff as soon as they had been admitted which had put them at harm and staff had struggled to look after them effectively. The person's risk assessment stated that 'Staff may need specialist training.' Staff had not received relevant training to enable them to meet the needs of people with this diagnosis. There was no evidence to demonstrate any further training had been arranged for staff to enable them to support this person effectively. Some people had a forensic history, a member of staff told us they had requested training in this area but this had not been arranged. There was a lack of evidence to demonstrate staff had received training in drug or alcohol issues. A social worker and a community psychiatric nurse told us they had concerns staff had not received an adequate level of training for their role. Not all staff had received an appropriate level of training to meet the complex needs of the people accommodated.

The failure to ensure staff had undergone appropriate training to enable them to carry out the duties they were required to perform was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on the Deprivation of Liberty Safeguards (DoLs) as part of their Mental Capacity Act 2005 training. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLs ensure any restrictions upon people's liberty are made in accordance with legal requirements. There were restrictions placed upon people's liberties. There were blanket restrictions in place. These are rules or policies that restrict a person's liberty and other rights, which are routinely, applied to all people within a service, without individual risk assessments in place to justify their application. For example, the fridges in both kitchens were locked and people had to ask staff for access. There was a dry food cupboard in one of the houses where all the dry foods people liked for tea such as soups and pot noodles were stored, which people had to request access from staff at tea-time. When there was a sleeping member of staff in one of the houses the kitchen in that house was closed to people after 22:00, although they could access refreshments and snacks in the dining room. People were not permitted to watch the communal TV's before 17:00. People had an allocated day to use the washing machines. A person told us if they could not access the laundry on their allocated time and day they had to wait another week to do their washing. Three people told us if they wanted to smoke at night the garden lights went off at 22:00. Staff were able to account for why these limitations were in place. For example, access to the communal television was restricted in the day to encourage people to participate in activities. However, there was a lack of written risk assessments to justify why restrictive practices were in place or to demonstrate their use had been regularly reviewed with people.

The failure to evidence why restrictive practices were in place or to monitor their use was a breach of Regulation 13(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

People did not provide positive feedback about the quality of the meals. One person told us, “It's not brilliant” and “Some meals are better than others.” Another person said “It isn't too bad” whilst one person said “The food is a bit cold but then it always is.”

Staff told us people had a choice of main meal but they were required to choose their meals five weeks in advance. This did not take into account how they might be feeling that day, the weather, what they might have been doing or their personal preferences. The process for selecting meals was in place to support the smooth running of the service rather than to meet people’s individual needs.

At lunchtime a hot meal arrived for people from another of the provider’s locations to be served by staff. People were served either goulash or macaroni cheese with croquette potatoes, carrots and parsnips. Although a person had diabetes and others were overweight staff did not consider whether it was appropriate to serve them two portions of carbohydrate. Staff provided meals of equal size portions for all people. People were not asked about what size portion they wanted although some were overweight and others were underweight. No regard had been given to people’s dietary needs or preferences in the plating up of their meals by staff. The meal, once it was served did not look appetising. A person showed us their lunch and commented “What do you think of the food then? It's not brilliant, is it?” Another person used the word “Slops” to describe their lunch. Records of a residents meeting on 28 July 2015 demonstrated people had requested an improvement to the quality of the food, This had not been addressed by the provider as at the following residents meeting on 31 August 2015 people had raised the issue again saying meals were ‘Hit and miss.’ The meals served were not of a good quality.

The failure to provide suitable and nutritious food and to enable people to make meaningful choices about their food was a breach of Regulation 14(1)(4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records demonstrated people had been weighed regularly to monitor if they had lost or gained weight. The registered manager told us they were in the process of introducing the Malnutrition Universal Screening Tool (MUST). This is a screening tool to identify adults, who are at risk from either malnourishment or being overweight. Action was being implemented to ensure people were screened for the risk of weight loss. Records showed people had seen the dietician where required in relation to their weight and staff told us they encouraged people to eat healthily.

People told us they had been consulted about their care plans, however, not all people‘s records provided documentary evidence of these discussions or their signature.

Records demonstrated 12 of the 13 frontline staff had completed training on the Mental Capacity Act 2005 (MCA 2005). The MCA 2005 provides the legal framework for when people have been assessed as lacking the capacity to make a decision for themselves. There was evidence that staff had made arrangements with people’s social workers to ensure mental capacity assessments had been completed. These were completed when people were believed to lack the capacity to make a specific decision for themselves. The principles of the MCA 2005 requirements had been followed where people lacked the capacity to consent to specific decisions about their care and treatment.

People told us that they had no difficulty in getting appointments to see healthcare professionals. People had been supported by staff to engage with services. Records demonstrated people had been supported to see GP’s, nurses, mental health services, opticians, dieticians and occupational therapists. Records demonstrated a person with a learning disability had been supported to have their annual physical health check. All people with a severe and enduring mental illness should also be offered an annual health check. The registered manager was aware of the need to ensure this took place and intended to address this for people.

Requires improvement

Is the service caring?

Our findings

On Monday to Thursday people's hot meal was provided from another of the provider's locations. The hot meals were delivered to number 74, where staff served these meals for people living there. People from number 76 would then come to number 74 to carry the food to number 76, across the open courtyard, to have their meals served to them there.

Following a recent medicines incident staff had taken measures to store people's medicines centrally to ensure medicines were stored safely. This meant that when people came to receive their medicines other people could see them, which was a potential breach of their privacy. The provider had not considered that any medicine administration process in place must also enable people to have privacy when they received treatment, for example, by taking people's medicines to them in their bedroom. People's privacy when being given medicines had not been considered within the revised medicine administration arrangements.

People were provided with mixed sex accommodation within both houses. People were accommodated across three floors in each house. People all had their own bedroom but some bedrooms neighboured people of the opposite sex. There was a lack of evidence to demonstrate the provider had given due regard to people's personal history and their potential vulnerability when deciding that it was appropriate to place them in mixed sex accommodation. There was no evidence available identifying whether mixed sex accommodation had been assessed as suitable and would adequately meet people's need for privacy and dignity. There was a lack of evidence to demonstrate people had been consulted about whether they wished to be in shared accommodation. Some people living at the location had to share access to toilet and bathing facilities with people of the opposite sex. Some people had a history of experiencing sexual abuse and there was a potential risk they may have not felt safe or comfortable being required to use shared facilities.

People's need for privacy and dignity had not always been met which was a breach of regulation 10(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with provided positive feedback about their relationships with staff. One told us "They're lovely" and another commented "They're really good. They're always willing to help and give their time when they can." A person told us "They encourage us to do things for themselves."

Staff were observed to speak with people respectfully and in a kindly manner. People were seen to be happy to speak with staff as they wished and approached them freely. Staff clearly understood people's needs and wishes. Staff spoken with were able to tell us about people's individual care and support needs and how these were met. People benefited from the continuity which they experienced in staffing, as there was no use of agency staff. People benefited from positive relationships with the staff who were providing their care.

The activity co-ordinator told us they prepared a fortnightly activity schedule based on people's interests. They were observed to sit down with people individually and ask them for their views on what they wanted to do. The written activity schedule noted when activities had been suggested by specific people demonstrating their involvement in the planning of group activities. People had been involved in making decisions about the content of the activities schedule.

The activities co-ordinator was making a birthday cake with a person. They demonstrated the stages of making the cake to the person and then let them do it. The person clearly enjoyed the activity and felt proud of their achievement. Important events such as people's birthday were recognised and people were encouraged to participate in activities and to gain a sense of well-being from them.

People's records showed they had been provided with a copy of the service user's charter. This stated people had the right to be consulted and have their views listened do about any provision that directly affected them as an individual. People had received information about their rights within the service.

People's records demonstrated their permission had been sought to share information about them where required with other agencies and within different aspects of the service. For example, people were asked for their permission before the Wellness Recovery Action Plan (WRAP) co-ordinator shared details of what they had

Requires improvement

Is the service caring?

covered on the programme with their keyworker. This gave people control over who had access to information about them. People were asked and consulted before their information was shared with others.

Requires improvement

Is the service responsive?

Our findings

People told us they were involved in planning their care. One person told us "A couple of weeks ago we put a new care plan together." They explained that this was done with their keyworker. The person told us "We got a new thing at the moment ... about goals and things." They explained that "We do it monthly and then look at our care plans." Staff told us all people met monthly with their keyworker, who was a staff member with overall responsibility for the person's care plans. During this meeting they reviewed the person's care plans and risk assessments. Staff told us the registered manager had introduced an additional requirement for keyworkers to now meet weekly with people to set and review goals with them.

One person told us "I reckon I have one (care plan) about almost everything." They also told us they "Felt I'd been involved." The service user plan policy stated 'Planning care and support is person-centred' and people had told us they felt involved in their care planning. However people's care plans and risk assessments did not always consistently demonstrate their involvement and were not always signed by them to evidence their participation and agreement. The registered manager told us they were aware the care plan format needed to be reviewed to ensure the focus was on the individual and that they were more fully involved in their care planning.

People's needs had been assessed and re-assessed using the provider's '3 step enablement programme assessment.' People were assessed in relation to their mental health and capacity, personal hygiene and self-care skills, social development skills, communication skills, personal mobility skills and safety skills, household living skills and moving on. They were then rated levels one to three for each area depending on their ability and understanding. This enabled staff to gauge people's progress over time. The summary of assessment sections were not always completed fully by staff to provide a more comprehensive review of people's progress.

Staff told us the aim of the service was to enable people to move on from the service to more independent accommodation, where possible. People were supported by staff to develop their independent living skills. A person told us they were working towards becoming more independent and that to support them with this goal staff helped them to prepare their own food. People were supported by staff to develop skills to enable them to live more independently.

Staff told us and records demonstrated they used the mental health recovery 'Star' with people. This was designed to support individuals in understanding where they are in terms of their recovery, the progress they are making and to enable discussion of people's mental health and wellbeing. A person told us "We do an Outcome Star about once a month." They told us this enabled them to review their progress and added "It's good for self-esteem." The Wellness Recovery Action Plan (WRAP) co-ordinator told us all people were also offered the opportunity to participate in the provider's WRAP programme. This was a newly introduced 13 week programme of 1 ½ hours per session with the provider's WRAP co-ordinator. The purpose of WRAP was to support people with a framework they could use to develop an effective approach to help them with distressing symptoms and unhelpful behaviour patterns. Staff were utilising recognised tools and models with people to support them in their recovery.

The registered manager told us people had been supported to attend external community based activities such as voluntary work and college. They were trying to use staff skills and interests to support people with their activities. For example, one member of staff had a sports background so they were trying to use their skills to engage people more proactively with exercise. The activity co-ordinator prepared a weekly programme of activities with people. This involved activities both within the service and the community. Activities included walks, singing group, weight watchers, cooking, coffee shop visits, pottery, swimming, seasonal activities, bowling, garden centre visits. The schedule showed there were no planned activities for Saturday's when people needed to make suggestions to staff. On Sundays the only planned activity for people was swimming. There was a lack of any planned alternatives for those who did want to participate. People told us they would like to see more activities at the weekend. One commented "We need to do activities at weekends.' They explained that "In the week we've got the activities co-ordinator ... but not at weekends." Another told us "I think I would like there to be more at weekends." People felt there was insufficient stimulation for them at weekends.

Requires improvement

Is the service responsive?

Regular residents' meetings were held to enable people to give their views of the service. The meeting was chaired by a member of staff, who opened the meeting by informing people they would go through the 'Fixed agenda' first. This included Health & Safety Maintenance Issues, Safeguarding, Complaints and Compliments. It was not clearly demonstrated how people were involved in organising the residents' meeting and putting together an agenda which was meaningful to them. Although the meeting was called a residents' meeting it was chaired and run by staff rather than people having control of the meeting and its content. The registered manager told us they were aware people needed to be more in control of changes to the service. They told us they were looking at the introduction of a residents' committee to be involved in policy making. Whilst this was positive it demonstrated the current residents' meetings were not fully effective at ensuring people were being empowered to run their own meeting.

There was a complaints policy in place for both written and verbal complaints. People had access to an accessible version of the policy if they required it in this format. There was also a complaints/compliments box in the lounges of both houses so people could anonymously provide their feedback. Two complaints had been received this year. Records demonstrated both had been investigated, appropriate action taken to address them and feedback provided. There were processes in place to encourage to make a complaint if they needed to and complaints had been investigated and responded to appropriately.

Requires improvement

Is the service well-led?

Our findings

The provider did not have a robust quality assurance process in place to identify all the issues which required attention and to enable them to take action to address them. This is necessary in order to drive service improvements.

The provider completed a number of audits in different areas to assess the quality of the service. These included medication on 30 October 2014 and then areas inspected by the Care Quality Commission (CQC); Safe on 22 December 2014, Caring on 22 January 2015, Responsive on 19 June 2015 and Well-led on 1 July 2015.

Following each audit areas for service improvement had been identified and an action plan written. However some of the action plans did not identify who was responsible for ensuring completion of each action or set a target date for completion.

There had been no action taken to either address the issues identified within each plan or to monitor the progress made against each plan up until 28 July 2015 when they were provided to the registered manager. The registered manager had commenced work for the provider in May 2015 but had not been provided with the audits immediately to enable them to commence work on them to drive service improvement. Records showed the registered manager had completed a number of actions since 28 July 2015. The audits had not identified or addressed the issues identified over the course of this inspection. The arrangements in place to monitor the quality of the service and drive improvement through the audit process had been ineffective.

People's pre-admission assessments were sparse and lacked sufficient depth of information about their needs and risks. There was a lack of consistency in the completion of people's pre-admission assessments. One person's pre-admission assessment was undated and covered one page whilst another person's covered one and half pages. They contained insufficient information to demonstrate how the decision to admit the person and their suitability for the placement had been reached. Some people's care plans contained minimal information about what support people required and how this was to be provided. One person's mental health care plan contained two short sentences to describe their trigger factors which might place them at risk of relapsing. There was a lack of detail about when the trigger factors were likely to occur or any protective factors likely to reduce the risk of them occurring or any strategies to known to help them. Their signs of relapse were also very brief. For example it stated 'Mood change' with no indication of what this might entail in terms of their mood going up or down or them becoming agitated or aggressive. It stated they might experience auditory hallucinations but there was no reference to any previously known information about how they experienced these to help staff understand the form they might take. For example, whether they commanded the person to do things which might put them or others at risk of harm. There was also limited information for staff in the actions to be taken to support the person before they went into crisis. People's records were not complete.

The failure to effectively operate systems to assess, monitor and improve the quality of the service and to maintain accurate and complete records of people's care was a breach of Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has a generic statement of purpose (SoP) which covered all of the services they offered. It did not specifically detail who the service at Park Avenue Residential Home was for or detail the objectives of the service provision. The SoP did not state they provided a service to people with a forensic history or a history of drug/alcohol misuse however they were doing so. There was a lack of written clarity about what the aims and objectives were for the service, whether to support and accommodate people with chronic long-term mental conditions or whether to offer a rehabilitation service to people with multiple issues. This information was not provided either in the SoP or a mission statement for the service. It was not clear to people and commissioners of the service what type of care could be provided and which people this would be suitable for. A staff member told us there were lots of vulnerable people living at the service and there should be more clarity on the purpose of the service. The lack of written clarity of had resulted in the admission of a mixture of people with very diverse needs, for whom it had been difficult for staff to safely and effectively meet some people's needs.

The SoP stated that the provider believed in the value and dignity of people. However, the evidence gathered during the inspection demonstrated people had not been always

Requires improvement

Is the service well-led?

been sufficiently valued to fully assess, mitigate and manage risks to them in order to keep them safe. It stated there was a commitment to training which all staff would be supported to undertake, however, not all staff had been supported to undertake relevant training.

A staff member told us morale at the service was low as they had been through a challenging time. The last staff meeting was held on 16 October 2015, where it was noted staff were unhappy. We spoke with the registered manager who informed us they had identified tensions within the team, These had been discussed with staff them at the last meeting and were going to address on an on-going basis through staff supervisions. The registered manager was aware of issues of morale within the team and was taking action to address this.

The registered manager had been in post since May 2015. Staff told us "He is an excellent manager he acts on things. He is learning fast." Another told us "The door is always open". Staff told us they could speak with the providers freely. Although staff told us they could speak with the registered manager the location of their office and its design was not conducive to encouraging staff or people to speak out. The registered manager's office was in a conservatory attached to one of the houses. Their office was very visually exposed, so if any person or staff member wished to speak with them confidentially this would have been difficult. They would have been in full view when they approached the office. This was not conducive to creating a culture where people could discreetly raise any issues they needed to with the registered manager.

The registered manager was supernumerary; however the newly appointed deputy manager had no supernumerary hours and spent all of their time working shifts on the floor. Supernumerary is when the member of staff is not providing direct care and is additional to the staffing required to meet people's care needs. Although there was a deputy manager they were not allocated any time to carry out the duties of a deputy manager. When the registered manager was away on leave the deputy manager covered them, however, as they were still working shifts on the floor there was a lack of available on-site management for people at these times. There was only one senior support worker. Although experienced staff were allocated to lead shifts, not all staff shifts were led by a senior member of staff. There was insufficient allocated senior management time to ensure the safe and effective running of the service.

Records showed the registered manager had received only one formal one to one supervision on 30 October 2015. They had started their post in May 2015. The registered manager and the providers told us informal support and telephone support was readily available. However, the registered manager had a background in managing services for people with a learning disability and not mental health and therefore required additional support to enable them to make this transition. There was a lack of evidence to demonstrate the registered manager had received sufficient formal supervision to support them fully within their role.

Quality surveys for completion by staff, families and care managers were underway. The initial results which required further analysis showed that the service was scoring between three and five (five being the highest) in terms of satisfaction. The views of people, staff and stakeholders were being sought through the quality assurance process.

The registered manager told us they worked with a range of agencies and with a number of community mental health recovery service (CMHRS) and home treatment teams to provide people's care. Records showed they had made concerted efforts to work with other agencies. They told us there had been issues with ensuring the service consistently received the level of support from mental health services they required to enable them to meet the needs of all of the people in their care safely and effectively.