Supreme Care Services Limited

Fir Trees House

Inspection report

283 Fir Tree Road
Epsom
Surrey
KT17 3LF

Tel: 01737361306

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Fir Trees House is a care home providing accommodation and personal care for up to seven people with learning disabilities or mental health support needs. There were six people living at the service at the time of our inspection.

The inspection took place on 10 May 2017 and was unannounced.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been in post for seven months and supported us during our inspection. A manager was in post and supported us on the day of the inspection.

At our last inspection in November 2016 we found that there had been limited improvements made in the care and support people received. However there were continued concerns regarding the governance of the service, risks to people not being adequately assessed, safeguarding concerns not being reported to the local authority, staff training not being effective in supporting them in their role and people's needs were not being responded to in a person centred manner.

At this inspection we found that there were on-going concerns about the care and support people received. Risks to people's safety and well-being were not always identified and addressed. Staff were not aware of how they should support people with their behaviours and there was an atmosphere of tension within the service. Staff did not demonstrate an understanding of their responsibility to safeguard people from abuse and incidents of verbal abuse had not been reported to the local authority. Accidents and incidents were not effectively monitored to mitigate the risk of them reoccurring. Medicines were not always administered safely although medicines were stored and monitored appropriately. Maintenance concerns were not addressed in a timely manner and not all areas of the service were cleaned to a satisfactory standard.

Sufficient skilled staff were not effectively deployed. Two people living at the service had been assessed as requiring one to one support for periods of the day although this was not always provided. Staff spent their time performing tasks rather than actively engaging with people. The manager had not completed a dependency tool to assess the number of staff required to meet people's needs. Staff did not receive the training they required to complete their role. Not all staff had completed training in supporting people who may display behaviours which challenge and not all mandatory training had been completed. Staff told us they received regular supervision and felt supported by the manager. However, staff expressed concerns regarding the support they received from the provider. Recruitment checks were not fully completed to ensure that staff employed were suitable to work in the service.

People's rights were not always protected as the framework of the Mental Capacity Act 2005 was not

followed. People's healthcare needs were not always met and guidance from professionals was not always followed. People did not receive person centred support in line with their needs. Support plans lacked detail and did not provide guidance to staff on how to support people well. There was a lack of activities provided to people and people were not supported to follow their interests.

There was a lack of positive interaction from staff and people were not always treated with kindness. Staff did not acknowledge or demonstrate understanding of the impact that repeated incidents of shouting and abusive behaviour had on people's well-being. People were not supported to develop their independent living skills. Staff were not always respectful of people's home. Staff were observed to use an exasperated tone with people and on one occasion a staff member was heard to swear at one person.

There was a lack of managerial oversight of the service. There was no registered manager in post and the provider had not taken adequate steps to ensure this condition of their registration was met. There was a lack of communication and collaborative working between the manager and provider to ensure that the required improvements were implemented. There was a lack of quality assurance process and audits completed lacked detail. Records were not up to date and lacked the detail required to ensure people received consistent care. Feedback received on the quality of the service was not used to ensure improvements were made.

People told us they enjoyed the meals provided and were able to make choices about their food. Visitors to the service told us they were made to feel welcome and staff were friendly. There was a complaints policy in place and people and relatives told us they would know how to raise concerns. The provider had developed a contingency plan to ensure people's care would continue during an emergency.

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

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we found nine breaches of 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?

Inadequate

The service was not safe.

Risks to people's safety were not being adequately identified and addressed.

Staff had not recognised and reported abuse in line with safeguarding procedures.

Accidents and incidents were not effectively recorded and monitored to minimise on-going risks.

Sufficient staff were not appropriately deployed to meet people's assessed needs. There were insufficient recruitment checks to ensure staff employed were suitable to work at the service.

People's medicines were not always safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not all received training to meet the needs of the people and were unable to demonstrate that their learning in other areas had been effective.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not fully implemented which meant people's human rights were not protected.

People's healthcare needs were not always met and guidance from healthcare professionals was not always followed.

People were able to make choices regarding their food and drinks

Is the service caring?

Inadequate

The service was not caring.

People were not treated with dignity and respect.

There was a lack of positive interaction from staff.

People's privacy was respected.

Relatives told us they were made to feel welcome when visiting the service.

Is the service responsive?

Inadequate

The service was not responsive.

Staff were not always understanding of and responsive to people's needs.

Support was not planned and delivered in a person centred manner.

Activities were limited and people were not actively encouraged to develop interests.

There was a complaints policy in place and people and their relatives told us they knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

Sufficient action had not been taken to address and maintain improvement in relation to the previous identified breaches of regulations.

Audit systems were not in place to monitor and assess the quality of the service and shortfalls in people's care had not been identified or addressed.

Records were not always kept and did not always contain consistent information.

Staff told us they felt supported by the manager.

Fir Trees 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.

This inspection took place on 10 May 2017 and was unannounced. The inspection was carried out by two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke to six people living at Fir Tree Road about their experience and observed the care and support provided to them. We spoke to the manager and two staff members during the inspection. Following the inspection we spoke to three relatives of people living at the service.

We reviewed a range of documents about people's care and how the home was managed. We looked at three care plans, medication administration records, risk assessments, accident and incident records, complaints records, policies and procedures and staff records.

Inadequate

Is the service safe?

Our findings

People and their relatives gave us mixed responses when asked if they felt the service was safe. One person told us, "Some of them here (other people) get at me sometimes." Another person told us, "I talk to staff if there's a problem." One relative told us, "The staff tell me they're scared of (family member). I do feel for them and the other people there but they need to learn to cope. I worry that (family member) will get into more trouble." Another relative told us, "We have no concerns at all. The staff are nice and there's no discrimination."

At our last inspection in November 2016 we found that risks to people were not always identified and managed, accidents and incidents were not monitored and safeguarding concerns had not always been reported appropriately. We also made a recommendation regarding the deployment of staff to ensure people's needs could be met safely. At this inspection we found that these concerns had not been addressed. In addition we found concerns relating to how people were supported with their medicines and the safe recruitment of staff.

People were not being protected against risks and action had not been taken to prevent the potential of harm. Risk assessments within people's care files did not always identify all risks present and did not contain effective control measures to minimise the risk of harm to people. One person's risk assessment identified concerns regarding their behaviour and vulnerability when going out alone. Monitoring forms showed the person had experienced a high number of falls when out and on a number of occasions had been supported back to the service by members of the public, paramedics or the police. Records stated that the person had refused staff support when going out so staff should record the time the person left and monitor how long they were out. However, staff told us that the person did not inform them when they were leaving the house, "(Person) opens the door gently so we don't know they've gone out." The manager told us the front door had an alarm fitted to alert staff when it was opened. We found the alarm was a brass bell placed above the door which did not ring if the door was opened gently. This meant staff were not always aware of the time the person had left the service and were therefore unable to monitor how long they had been gone. Monitoring forms also showed that the person could become verbally abusive towards others on their return to the service. There was no guidance in place for staff regarding how to manage these behaviours and how to support the other people. One member of staff told us people became anxious when they were aware the person was out as they were concerned how they would be when they returned. They said they felt this anxiety also led to an increase in their behaviours.

Records showed that another person also displayed behaviours which put themselves and others at risk. This included verbal abuse, threatening behaviour, damage to property and physical abuse. The person's risk assessment did not identify potential triggers to their behaviour. The guidance to staff provided stated they should remove other people from the situation, move objects which could be thrown and to be aware of person's mood to prevent situations escalating. There were no proactive strategies in place to support the person in developing communication skills or a structured routine to help reduce their anxiety. There was no guidance provided for staff in how to de-escalate situations or how to support the person to express their frustrations with other people appropriately. One staff member told us, "(Person) is a risk to other residents

and staff. Even though we've had MAYBO training (conflict management training) it is not really enough. Some staff are frightened." We asked staff if they were aware of the triggers to the person's behaviour and how they should support them. Staff told us they did not believe there were any triggers to the person's behaviour and said this was often directed at one individual. One staff member said, "When it is beyond our MAYBO knowledge we phone the police." Another staff member told us, "If (person) is shouting, we don't shout back. We'll move the other person away and leave them to calm down." Records showed the person had been involved in two incidents within the community which had led to police involvement. The associated risks were not clearly identified within their risk assessments and risk management plans did not address the concerns raised.

A third person had a risk assessment in place regarding 'Challenging Behaviour' which stated this may happen if staff ignored or did not engage with them. There were no details of the type of behaviours the person may display or the impact this may have. The control measures in place were for staff to have one to one time with the person and to write things down for them. The person's records stated they were funded to receive four hours one to one support each day. However, there was no evidence within the person's support plan or daily notes that this was provided and we did not observe the person receiving this support during the inspection. An additional risk assessment was in place with regards to self-neglect and the person staying in bed all day. Staff told us that this was an indication that the person's mental health was deteriorating although this was not recorded within the person's risk assessment or care plan. The control measure in place was for the manager to monitor the 'waking up sheet' within the person's care notes. This showed that the person had chosen to remain in bed on average three days per month although staff stated this happened more regularly. There was no evidence this had been monitored and no control measures, guidance to staff or support plan in place regarding these risks. A further risk assessment identified the person was at risk if they refused to eat due to a specific health condition. However, there was no guidance in place on how staff should offer support around mealtimes and food choices, what types of food the person preferred or the times they liked to eat. Records showed that the person had steadily lost weight during the past year. During the inspection the person told us they had not been able to eat their lunch as it had made them feel sick. We asked the manager to address these concerns.

A personal emergency evacuation plan was completed for each person to give guidance to staff should they need to evacuate the building. However, these were not regularly updated when additional risks emerged. Fire records showed that during a recent fire drill one person had refused to leave their room. The person's evacuation plan had not been updated to reflect this and give staff guidance on how to support the person should they refuse to exit the premises. We spoke to the manager who told us they were aware of these concerns and intended to monitor the next two fire drills and would update records if this continued to be a concern. We asked the manager to ensure that the records were updated to ensure the person was kept safe should an emergency occur.

Accidents and incidents were not effectively reviewed and monitored to protect people from them happening again. Staff reported incidents either on incident reporting forms or on behaviour monitoring charts. There was no guidance in place for staff on which form to use for the type of incident which had occurred. The manager had completed reviews of incident forms although these reviews did not lead to significant changes in the way people were supported and risk assessments were not routinely updated. Records described an incident where one person had become angry and threatening towards another person. They had then broken furniture resulting in an injury.. The manager's review of this incident did not fully address the concerns and did not recommend any changes to the person's support as they did not believe there were any triggers to the person's behaviour. Other incidents where one person had been returned to the service by ambulance due to experiencing falls had been recorded on the person's monitoring chart. No incident form had been completed and the manager had not reviewed the concerns

raised.

People's medicines were not always administered safely. During the inspection we observed one staff administer medicines to two people. The staff member dispensed both people's medicines from their respective pharmacy boxes at the same time into two separate containers. They did not cross check the medicines were correct against the medication administration records (MAR). The staff member then took both pots of medicines into the lounge area. Administering medicines to two people at the same time meant there was a risk of the medicines being administered to the wrong people. The staff member held a medicines pot out to one person without checking they had a drink to take their medicines with. They then moved to the second person and tipped the medicines into their hand. One tablet fell onto the floor and the staff member picked it up and placed it into the person's hand. The staff member did not wash their hands either before or after administering people's medicines. We noted in one person's MAR chart there was a gap in the administration of one medicine the previous day. The medicine was not in the person's medicines box which indicated that staff had not recorded that it had been administered.

The lack of effective risk management systems and safe medicines management processes was a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely in a locked medicines cupboard. Staff checked the temperature of the medicines cupboard on a daily basis to ensure that medicines were stored within the set limits. Stock checks of medicines were completed regularly and any unused medicines were returned to the pharmacy in a timely manner. The pharmacy who supplied medicines to the service had recently conducted an audit of the systems used. There were no significant concerns identified and we saw the recommendations made had been followed.

Staff did not demonstrate a good understanding of how to keep people safe from abuse. There was a tense atmosphere between people throughout the inspection. On a number of occasions people were heard to speak to each other in a derogatory manner and raise their voices. Staff sat in the lounge intervened to ask people to stop although they were not observed to offer people alternative activities or support people in a pro-active manner. On one occasion a staff member swore when asking one person to stop shouting at someone else. The staff members we spoke to told us they did not believe that people shouting at others was a form of abuse and said this was a daily occurrence. This demonstrated that staff had not identified instances of verbal abuse and had not ensured these were fully recorded. Instances of verbal abuse had not been shared with the local authority safeguarding team to enable them to investigate concerns and ensure people were living in a safe environment. Following the inspection we spoke to the local authority to inform them of our concerns.

The manager had reported a number of safeguarding concerns relating to physical abuse and individual behaviours to the local authority safeguarding team. However, they told us that when they were away from the service staff would not report safeguarding concerns but would wait for them to do this on their return. This had led to a delay in the reporting of two safeguarding incidents which presented a risk of the concerns re-occurring.

The failure to ensure systems and processes were in place to protect people from potential abuse was a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient staff were not deployed to meet people's assessed needs. We asked staff if there were sufficient staff on duty to support people. One staff member said they did not think there were sufficient staff. They

told us, "Staff are stressed and so are people." The manager told us that the service operated on a basis of one staff member supporting four people. As there were only six people living at Fir Trees Road and two staff members on duty at all times they believed that staffing levels were exceeded. However, the manager did not complete a dependency tool to determine the staffing levels required. The manager told us that where additional staffing was required for activities this was provided. We looked at the rotas for the past nine weeks and found that additional staffing had been provided on six occasions. One member of staff told us that they thought there were enough staff to support people.

Records showed that two people were funded to receive one to one support each day. One person was funded to receive four hours one to one support each day. The manager told us that this was used to support the person with their personal care, emotional support and activities. However, the manager was unable to provide evidence of how these hours were used in practice and records showed the person attended to their own personal care needs. We observed the person moved around the service during the morning, asking staff questions and spending some time in the garden. They spent the majority of the afternoon in bed. Another person was funded to receive three hours one to one support each day. The manager told us the person was supported to visit their family one day each week which used six hours of their support. They were unable to evidence how the remaining hours were used. We observed the person spent the majority of the day laid on the sofa or sleeping in their room. During the day both people appeared anxious at times.

The failure to ensure sufficient staff were appropriately deployed to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were not always followed. We checked the recruitment records of four staff members. All four files contained Disclosure and Barring Service (DBS) certificates which were obtained by previous employers, three of which were dated 2015. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. There were no references on file for two staff members. The failure to obtain up to date DBS checks and references meant there was a risk of staff who were not suitable to work in care services being employed.

Insufficient recruitment checks to ensure staff employed were suitable to work at the home was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance concerns were not addressed in a timely manner. A recent visit from the local authority had identified a number of outstanding maintenance concerns including a bath hoist chair not working, the gas cooker door not fully closing, and a broken toilet seat. The manager told us all repairs had been discussed with the maintenance contractor who would be completing the work the following week. During our inspection one person told us the bath seat had been broken for some time. They said this meant they had to climb into the bath and stand up for a shower which was difficult for them. The maintenance log showed that the bath chair had been reported broken in August 2016 although an engineer visit had not been booked until September 2016. The manager told us the outcome of the engineers visit was that the bath chair was beyond repair and needed to be replaced. They were therefore discussing the most appropriate action to take with the provider.

Another person asked us to look at their en-suite shower. There was a black substance covering significant areas of the shower tiles and tray. The manager told us this had occurred during the past week and was due to be investigated by the maintenance contractor. However, this appeared to be a long standing issue. Minutes of the residents meeting in March 2017 showed the person had expressed concerns regarding the damp in their shower. There was no record of any concerns regarding the shower within the maintenance

logbook. We requested the shower be cleaned during the morning of the inspection but found this had not been done when further checks were made in the late afternoon. The manager assured us this would be completed immediately. The toilet handle in the upstairs bathroom was wooden and had worn away meaning germs could be harboured.

Areas of the service were not cleaned to a satisfactory standard. There was a cleaning schedule in place which detailed the cleaning tasks to be completed. We found that tasks relating to people's individual rooms had not been signed to show they had been completed. We observed one person's room was dirty and dusty and there were stains down one wall. Another person's room was cluttered and dust was present on surfaces. Communal areas were generally clean although there were stains on walls and cobwebs present in the lounge and hallways.

The failure to ensure that maintenance concerns were addressed in a timely manner and the lack of adequate cleaning in all areas was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that fire equipment was regularly serviced and that other health and safety checks were completed by relevant professionals. There was a contingency plan for staff to follow should an emergency occur to ensure people would continue to receive support. Staff were aware of where people should be taken in the event the building could not be used.

Requires Improvement

Is the service effective?

Our findings

At our inspection in November 2016 we found that people's rights were not always protected as the Mental Capacity Act (MCA) 2005 was not being followed. We also identified the training staff received had not been effective in supporting them in their role. At this inspection we found that these concerns had not been adequately addressed and identified additional concerns regarding the monitoring of people's health care needs.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's rights were not always protected because staff did not act in accordance with the MCA. One person's file contained a recent DoLS application to restrict their movements by locking the front door.. There had been no capacity assessment completed regarding the decision and no best interest meeting had been held to discuss the possible implications. We asked the manager about how they intended to implement the proposed restriction as it had not been implemented. They told us they believed the person did have capacity to understand the risks of leaving the service unaccompanied and said they did not believe they would be able to stop the person leaving. This demonstrated a lack of understanding of the MCA framework and the need to ensure people's rights were protected.

Records showed that another person had limited access to their money and was given a set allowance each day. This had led to two incidents where the person had become angry at not being given full access to their finances. There was no assessment in place regarding the person's capacity to manage their finances and no best interest records to determine if the current arrangements were the least restrictive option. No DoLS application had been submitted regarding this restriction. The manager told us the restriction had been implemented at the request of the person's family. There was no documentation available to show the person's family member had the legal authority to make this decision. There was no mental capacity assessment in place regarding one persons need for constant supervision or financial support and no DoLS application had been submitted to the local authority. This concern had been raised at our last inspection in November 2016.however; no action had been taken since this time.

Failing to protect people's legal rights in line with the Mental Capacity Act 2005 was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unable to demonstrate the skills, knowledge and understanding needed to carry out their roles and support people effectively. The manager maintained a record of training attended by staff. This showed that not all staff had completed mandatory training in areas including food hygiene, medication and fire

safety. Three of the eight staff employed had completed a training programme in supporting people who may display behaviours which challenge. This meant that five staff members had not had appropriate training to support people effectively. Staff did not demonstrate an understanding of how to support people in a proactive manner, identify triggers to behaviours and prevent situations from escalating. Safeguarding training had been completed by all staff although this had not been effective in ensuring staff were able to identify and report potential abuse. Training had been delivered to staff in MCA and DoLS. However, staff had not ensured this learning had been implemented in practice. Following the inspection the manager informed us that training had been scheduled for staff in food hygiene, fire safety, medication and the MCA.

Failing to ensure that staff received effective training to carry out their role was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's care records contained a letter from a healthcare professional which made a number of recommendations regarding how staff should support the person. This included ensuring the person had access to support regarding their sensory impairment and the development of alternative communication systems. There was no evidence that this work had been initiated and the suggested referrals to other healthcare professionals had not been made. We spoke to the manager about this who told us the person regularly refused to attend medical appointments which had made it difficult to make referrals through their GP. However, this had been addressed by the healthcare professional making the recommendations with guidance as to how this difficulty could be overcome by making direct referrals.

People's weight was monitored monthly although action was not taken when significant changes were noted. One person's records showed they had gained a significant amount of weight over the past six months. Another person's records evidenced they had lost weight consistently over the past three months. There was no evidence available to show that these concerns had been addressed and no records of discussions with healthcare professionals to check for underlying health concerns. The manager assured us that appointments would be made with the people's GP following the inspection.

Failing to ensure that people's healthcare needs were met and the advice of healthcare professionals followed was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In some areas we found that people received support to address their healthcare needs. There was evidence that people were supported to attend health appointments including the GP, opticians and dentists as well as specialist appointments. Records of appointments were maintained to enable staff to track when follow-up appointments were required.

People were offered choices regarding their food and drink and told us they enjoyed the food provided. One person told us, "They're all good at cooking." There was a menu displayed in the communal lounge and people were able to choose alternatives. We heard on person tell the staff they would prefer something different for lunch and saw that this was provided. Minutes of the residents meeting showed that food preferences were discussed and suggestions made by people were added to the menu. People were able to choose where they ate their meal. One person told us they preferred to eat their meal in their room, another person sat in the lounge area. People were able to make their own drinks and snacks and we observed them doing this regularly throughout the day.

Inadequate

Is the service caring?

Our findings

People and their relatives told us that staff were caring. One person said, "I am very, very happy here. I get no grief from anyone." One relative told us, "(Family member) has nothing but praise for the staff which makes us feel positive. They all seem nice."

At our last inspection a recommendation was made that the provider ensured people's care was personalised. At this inspection we found that the concerns had not been adequately addressed and that people's needs were not being met in a holistic and caring manner.

Staff did not always engage with people in a meaningful and respectful manner. On a number of occasions during the inspection we heard staff use an exasperated tone when speaking to people. The manager told us that one staff member was required to spend their time in communal areas to identify any conflict between people. Although this direction was followed by staff there was little engagement or positive interaction with people. We observed the staff member spent their time writing notes whilst sat in the lounge. They did not take the time to engage or make conversation with people, only responding briefly when people spoke to them. One person went to the staff member and said, "Oh my lovely" and moved towards them to give them a hug. The staff member pulled away from them and continued writing care plans without acknowledging them. On another occasion the person showed a staff member they had changed their trousers and was clearly pleased with how they looked. The staff member responded to the person by saying, "I can see that" and carried on writing. We observed one person becoming angry with a second person. The staff member continued writing their notes and said to the person, "Stop that, you need to be good." They did not ask either person how they could help or try to engage them. After a short time the second person left the lounge and went to their room.

Staff did not acknowledge or demonstrate understanding of the impact that repeated incidents of shouting and abusive behaviour had on people's well-being. We observed two incidents where people shouted at other people and used derogatory comments. On one occasion this behaviour was ignored by staff and on the second occasion staff asked the person to stop. However, the people subject to these comments were not offered any comfort and staff did not check how they were. On both occasions the people went to their bedrooms to avoid the conflict.

Staff did not always demonstrate understanding and respect that they were working in people's home. The manager's office was adjacent to the lounge. This meant that staff needed to walk in front people whilst they were watching television. Staff did not acknowledge this interruption to people or apologise for getting in their way. On one occasion we observed a staff member stand directly in front of someone whilst having a conversation with the manager. The person had to adjust their position to look around the staff member and see the television. Residents meeting minutes for April 2017 stated that staff had noticed that people were using staff cups and this shouldn't happen. We spoke to the manager about this who told us they acknowledged this was disrespectful to people living at the service.

We observed one person sat in the lounge on a dining room chair and appeared uncomfortable. They told

us that they were doing this as the sofa was too low for them and they struggled to get up. We spoke to the manager about this who told us this had been the case for a short time and they intended to make a referral for the person to be assessed for a more suitable chair. There was no evidence that this referral had been made or any alternative seating had been offered to the person. This showed a lack of care for the person's comfort.

Not ensuring people were treated with respect and was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not actively encouraged to develop their independent living skills. At our last inspection in November 2016 the manager told us they had begun to implement systems to ensure people developed their independence and skills. We observed people cooking, cleaning and staff supporting people with a range of domestic tasks. At this inspection we found that this had not been sustained. Staff told us that they continued to ask people to be involved but they refused. There was no guidance to staff in people's care files regarding how they should encourage people to be involved, use existing skills or what tasks people enjoyed. When speaking to people about their involvement staff did not offer encouragement or guidance. We observed one staff member approach a person and say, "You need to come with me when I'm cooking today." The person responded with a smile and said, "I can't, I'm going back to bed." The staff member said, "So you're refusing?" whilst walking away. The staff member did not offer any encouragement or attempt to engage the person in the task. We observed that people continued to complete domestic tasks which they had done for many years with minimal staff support. On arrival at the service one person was hanging up their washing and later in the day one person helped to empty the dishwasher.

Not ensuring people received support to maintain and develop their independence was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we also saw some positive interactions between people and staff. One person asked staff for support with their personal care but became distracted. The staff member reassured the person they were ready to help them and waited for them to finish what they were doing. On another occasion a person was struggling to take their washing outside. The staff member observed this and said, "Let me help you with that." A staff member asked one person if they would help them empty the dishwasher. The person shouted at the staff member saying they didn't want to. The staff member told the person they would like it if they helped them and that they were going to the kitchen. We observed the person went to the kitchen to help after a few minutes.

People's privacy was respected. We observed staff knock on people's doors before entering and ensuring personal care was carried out with the doors closed. A number of people chose to spend time in their rooms during the day and staff respected this. One person told us, "I like my room, I can go there when I like and staff don't bother me." Another person required staff support to keep their room clean but did not want this to be done whilst they were present as they wanted to maintain their privacy. There was a written plan in place regarding this and the person had signed to show their agreement.

Visitors to the service were made to feel welcome. One person told us their family visited regularly and were always treated well by staff. One relative told us, "The staff are definitely welcoming. They are all very pleasant." There were no restrictions on the times family members could visit.

Inadequate

Is the service responsive?

Our findings

We received mixed responses from relative when speaking to them about the care their relatives received. One relative told us, "We couldn't be happier, It's been such a relief after our last experience." Another relative said, "I think there's thing that could be done more regularly, cleaning rooms for example, to help people get into a routine." A third relative told us, "I wish there was somewhere with more support. The staff know (family member) struggles but they don't work round it."

At our last inspection in November 2016 we recommended that the provider improved how people's needs were responded to and personalised activities were provided. At this inspection we identified that people's needs were not being met in a person centred way.

People did not always receive person centred support in line with their needs. One person's support plan stated that they would repeatedly ask the same questions throughout the day and staff should therefore answer three times before writing the information down for them to refer to. There was no guidance to staff on how this should be addressed with the person or where things should be written. We observed the person ask staff on numerous occasions about going out in the evening. The manager said they would write it down for the person and took a notebook to do so. However, this was not communicated to other staff who continued to answer the person's questions throughout the day using an increasingly exasperated tone. The person was not offered any alternative activity during this time to help alleviate their anxiety. Staff told us that that the person struggled to budget their finances which could create tension when they had no money available. There was no reference to this in the persons support plan and no measures had been implemented to support the person with their budgeting skills.

No action had been taken to support one person with their sensory impairment. We observed the person became frustrated on two occasions when people struggled to understand their verbal communication. There was no guidance available to staff regarding the person's needs in this area and no alternative communication systems had been explored with them. Another person was reluctant to leave the service to access community based activities. There was no guidance available to staff regarding how to approach the person regarding going out. The person's records showed they went out twice a month to places they were familiar with and had attended for many years. However, staff had not explored how to expand the person's social opportunities.

Support plans did not contain detailed guidance for staff regarding the support people required and goals set were not person centred. Support plans were completed using the same seven outcomes for each person. These related to areas including staying healthy, finances, quality of life and personal dignity. The objectives set in each of these areas were the same for each person and did not take into account their individual needs and skills. Plans highlighted areas where people required support but gave no guidance on how this should be provided. One person's plan stated they were reluctant to complete or accept support with their personal care. Their care plan stated they would be supported by staff with their personal care but gave no guidance on how the person should be approached, what elements of care they could complete themselves or how to respond if they refused. Records showed the person refused this support on a regular

basis. One outcome recorded in all care plans stated, 'To live safely, free from discrimination or harassment'. As reported, we observed that the atmosphere at the service was tense and people spoke to others in a derogatory manner at times throughout the day. There was no guidance to staff on how to support people effectively in this area.

People were not supported to follow their interests and there was a lack of social activities available to people. The majority of the people living at Fir Trees House were able to access the community independently when going to places familiar to them. One person told us they went for a walk and a coffee early each morning, two people went to visit their family members each week and another person regularly attended a church group. However, this left significant periods of time where people had no social activities planned. This meant people spent the majority of their time sat in the lounge area without anything to do which added to the tension between them. People appeared bored and three people were observed to spend time sleeping in their rooms during the day. Staff told us that when activities were planned people would refuse to attend. However, during the morning of the inspection people told us they were going to the pub for a drink in the evening and staff would be accompanying them. Three people made regular reference to this throughout the day to check the activity was still taking place. It was clear people were looking forward to this. Staff told us that the majority of activities offered were group activities rather than on an individual basis. Records showed that group activities took place on average every two weeks.

One relative told us, "(Family member) has nothing to do all day. They just wander around and get bored and that's when the trouble starts." The person's records showed they had a number of interests including swimming, cycling, football, and going to the gym. These activities were not planned for them on a regular basis and staff told us if they offered them the activities they would refuse. However, there had been no planning completed with the person regarding what activities they would do and which staff members they would like to support them. Recommendations from a healthcare professional working with the person made clear links to them having more meaningful activities to reduce the risk of them displaying inappropriate behaviours. They added the person related more positively to being supported by male staff. This was not recorded within the person's support plan and staffing rota's showed the person had limited access to male staff members. Another person's activity plan was blank with the exception of when they met with their family members. Staff told us this was due to the person's lack of funds. However, there was no evidence that low cost activities had been planned for them.

There were few activities planned with people. We asked staff about activities for people when they were spending time at home. One staff member told us, "The manager asked us at the last team meeting to all to think of five activities we could do with people." However, this was the same response we received during our last inspection in November 2016. Staff meeting minutes did not contain any reference to activities since our last inspection. Another staff member told us, "We are busy doing things. There is a lot to do with the cooking, cleaning and filling in daily records. But people don't want to do things. Like (name) today when they refused to help with the cooking." One person's records stated they had an computer tablet which they liked to play games on. We spoke to the manager about this who told us, "They have the iPad but we have so many problems with the Wi-Fi here that they don't use it very often." They told us they were unsure of what action was being taken to ensure the Wi-Fi was available for the person. They said, "I've reported it to the office but I don't know if anything's been done."

Not ensuring people received support in line with their needs, and care plans not being completed in an effective manner along with a lack of activities which suited people's individual needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place which detailed how a complaint could be made and how this would

be dealt with. The complaints book showed that no formal or informal complaints had been received since our last inspection. People and relatives told us they would know how to raise any concerns. One person said, "I'd speak to (manager)." One relative told us, "I've never done it but I'd ring and ask to speak to who was in charge."

Inadequate

Is the service well-led?

Our findings

We received mixed responses regarding the management of the service from people, relatives and staff. One person told us, "I like (the manager). I can tell them things." One relative told us, "I've never spoke to the manager as far as I know. I don't know who it is." Another relative told us, "The company who run it seem to be good. I've never spoken to the manager but I think this is because I haven't needed to. I'm sure they would contact me if there was problem though."

At our last inspection in November 2016 we found there was a lack of managerial oversight of the service. This was a continued breach of the regulations from our inspection in October 2015. There was insufficient monitoring of the quality of the service from the provider and manager. At this inspection we found that these concerns had not been addressed.

There was still no registered manager in post. The last registered manager left the service in April 2016. The current manager had been in post for seven months, they informed us they intended to leave the service in three weeks' time. They had submitted forms to register in January 2017 which had been rejected by the CQC as the information provided was not complete. They told us the provider had not informed them of this for several months at which point they had already made the decision to leave the service so did not resubmit their application. The provider informed us that they were aware the forms had been rejected and of the need to have a registered manager in post. They said they had taken steps to recruit a manager who they believe has the required skills and assured us they would start the registration process as soon as possible.

Effective systems were not in place to enable the manager and provider to work collaboratively to ensure that the required improvements were completed and legal requirements met. The provider told us they were not aware of the extent of the concerns that had been identified.

Staff told us they felt supported by the manager of the service but did not always feel they received support from the provider. One staff member said, "I get support from (the manager). They give us all the support we need. We can wait a long time for the provider to do anything. There are so many broken items in the home. I would expect them to carry out maintenance on the home regularly but they don't." Another staff member told us, "We're not supported by the provider. They don't come here enough. They are just not listening." Staff meetings were held at the service and records maintained. Meeting minutes showed that service issues including, medicines, policies and training were discussed.

Quality assurance systems were not effective in monitoring the quality of the service provided or ensuring continuous improvement. The manager told us that they were responsible for completing quality audits within the service although acknowledged this work had fallen behind whilst they had been working on completing the action plan prepared for the CQC following the last inspection. However, part of the action plan submitted was in relation to lack of quality assurance systems in place. Since the last inspection only two internal audits had been completed by the manager. One audit related to the review of care plans. This lacked detail and concluded that three care files were up to date and the remaining files 'required review'.

The quality of the information contained in care files was not reviewed and no further audits had been completed. This meant that the lack of information provided within people's plans had not been identified. The second audit, relating to risk assessments was completed in December 2016 and stated, 'All risk assessments being reviewed in line with CQC action plan'. No detail was available to show if individual risk assessments had been reviewed and what action was required. The manager told us at the beginning of the inspection and within their provider information return that all risk assessments and support plans were now up to date. However, we found that risk assessments were not robust and control measures to keep people safe were not in place. Support plans lacked detail and did not provide staff with guidance on how to support individuals.

Following the inspection the provider told us that two visits had been conducted by registered managers of other services to monitor the progress of the service action plan and the quality of support being provided. However reports of these visits lacked detail and did not comment on the quality or effectiveness of the support offered or the support plans and risk assessments in place. We spoke to the manager regarding the visits. They told us they had not received any feedback regarding any improvements required. We asked the manager if they had an action plan in place to ensure continued development and improvement. They told us they had been working on the action plan submitted to the CQC following the last inspection. They added they had ideas for improvement but had not formalised these into an action plan as they were leaving the service.

A resident's contract was held on each person's file and stated the aim of the service was to provide a comfortable, friendly and happy environment and the principles of privacy, dignity, independence, choice, civil rights and fulfilment would be observed. As reported we did not find that the service was upholding these principles and the service was not supporting people safely, effectively or with dignity.

Records were not accurately maintained. Staff recorded people's daily notes on a variety of different forms which covered different aspects of their support. Much of the information provided was repetitive and staff told us this took up a large proportion of their time. We found a number of records provided contradictory information. For example, staff reports for a one week period repeatedly recorded that one person's 'physical health and well-being were fine', that their 'mental health seems fine' and that the person 'did not present a risk to themselves or others'. However, the person's behavioural monitoring chart shows that there had been two incidents where the person had fallen over whilst out or had been abusive to other people living at the service. Each person had a Care Passport in place. This is a document designed to provide information to health care professionals about people's needs should they be admitted into hospital. We found the documents lacked detail and did not provide comprehensive information. The form for one person did not state they were diabetic or provide detail of how this condition was treated. Another person's form did not refer to their sensory impairment or the support they required around this. This meant that people were at risk of not receiving the right support to meet their needs in the event of being admitted to hospital.

During the inspection we spoke to the manager on three occasions regarding people's individual care. On each occasion the manager referred to meetings with social care professionals and the conversations which had taken place. We asked the manager where the information discussed was recorded. They told us that they were waiting minutes from one professional although in general the contents of meetings were not recorded. This meant that the outcomes of meetings were not available to enable monitoring and progress to be tracked. We asked the manager how this information would be known to others when they left the service. They told us that they would hand over the information to the new manager. Not ensuring information is updated as events occur means there is a risk that information will not be fully recorded and accurate.

At our last inspection in November 2016 we found that although feedback was obtained from people, relatives and other stakeholders regarding the quality of the service this was not used to ensure continuous improvement. Annual feedback questionnaires were sent to people involved in the service and we observed that comments were largely positive. However, we saw that where concerns were raised these were not responded to. At this inspection we found that no action had been taken to address the concerns raised in previous questionnaires. The manager told us that the next questionnaire was due to be distributed in the next few months.

The lack of effective management oversight, quality assurance systems and the failure to maintain accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.