Care Quality Commission

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Evaglades

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 8 December 2014.

Evaglades is a residential home situated on the promenade at Morecambe and provides accommodation and support to people with learning disabilities. It is registered to provide personal care for up to eight people. Each room has an en-suite. Rooms are located on two floors with a staircase. At the time of the inspection there were two people using the service.

A registered provider was in post at the time of the inspection. A registered person is registered with the Care Quality Commission to manage the service. 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.

At our previous inspection on 25 September 2013 the provider was assessed as meeting all the requirements set out in the Health & Social Care Act 2008.

Feedback from relatives in relation to care provision was positive. Family members stated that their relatives were happy living at the home. One person who had lived at the home for many years confirmed that they were happy with the care being provided.

Summary of findings

We observed staff being caring and interacting with people who lived there in a positive manner. We observed staff using touch and appropriate eye contact to enhance communication and aid interactions. People were treated in a dignified manner at all times, by all the staff.

People's health needs were monitored and any changes in health needs were acted upon in a timely manner. The home worked with other health professionals to ensure continuity of health care.

Medication was administered safely by appropriately trained staff using an individualised approach. We observed staff seeking consent from each person before administering medication. Staff informed us of people's preferences surrounding medication administration. We have made a recommendation about the management of medicines.

However, we noted that the safety of the people using the service was being compromised in a number of areas. We found that care plan records and risk assessment records were not always up to date. This meant that people were at risk of receiving inappropriate and inconsistent care because records were not completed appropriately.

We looked at staffing records and found that staff files were missing or incomplete. Staff files were missing references and not every staff member named as working at the home had all the required relevant documentation in place. For example not all staff had a Disclosure and Barring Certificate (DBS) or Criminal Records Bureau (CRB) checks in place. This meant that the registered provider had failed to safeguard people against unsuitable staff because thorough recruitment processes and checks had not been completed prior to commencement of employment. You can see what actions we told the provider to take at the back of the full version of the report.

Staff told us that they were appropriately trained to carry out their role. However we found a lack of systems in place to ensure that there were adequate numbers of trained staff on duty at all times.

The provider did not have an effective training matrix in place and could not verify all training attended by all staff as certificates were missing. Training had not been completed by all staff members in the area of safeguarding. One staff member stated that they knew what defined abuse but they were unaware of who to report it to, should the registered provider not intervene and act appropriately. This meant that people may be at risk of not being correctly safeguarded as staff may not be able to report it appropriately. You can see what actions we told the provider to take at the back of the full version of the report.

We also found that the provider did not facilitate communications between the staff members by holding regular formal supervision and team meetings. This shows that significant information held by individuals within the team may not be passed on or relayed to other staff members. This may lead to inconsistencies in delivery of care. You can see what actions we told the provider to take at the back of the full version of the report.

The home had a poor culture for supporting openness and change. Staff working at the home said that it was sometimes difficult to make suggestions to the registered provider which may be of benefit to the people using the service. You can see what actions we told the provider to take at the back of the full version of the report.

The provider did not seek feedback on a regular basis. The registered provider had not sought feedback on quality assurance as a means to highlight any areas of deficiencies in which improvements could be made. You can see what actions we told the provider to take at the back of the full version of the report.

We were informed that both people living at the home lacked capacity to make significant decisions. However there was no evidence of any capacity assessments being completed in relation to decision making. The provider was not following the Mental Capacity Act 2005 code of practice for people who lacked capacity to make a decision. There was also no evidence available to show that the provider had consulted with other significant people or any evidence of best interest meetings taking place. The provider had not considered making applications for the people who lived at the home to deprive them of their liberty. You can see what actions we told the provider to take at the back of the full version of the report.

We were concerned about the lack of activity and structure at the home. Whilst carrying out the inspection people were not encouraged to be active. The two people

Summary of findings

sat in the lounge all day watching TV whilst staff went about their jobs. We have made a recommendation about using good practice guidelines to improve the service.

You can see what actions we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not always safe.

People at the home were not safe as the provider had failed to put effective recruitment procedures in place. Not all staff had up been correctly vetted before commencing work for the home.

Although the registered provider had risk assessments in place they were not always regularly reviewed and updated. This meant that people living at the home had their health and safety compromised.

Is the service effective?

Requires Improvement

The service was not always effective.

We observed some positive interactions in which staff supported people to meet their needs. Staff responded in a timely manner and it was clear they understood people's requirements.

However, we observed that not all training had been completed by all staff members working at the home. Volunteers working at the home were also not adequately trained to complete the role in which they were working.

The registered provider had not completed training in the Deprivation of Liberty safeguards (DoLs). This meant that the registered lacked clear insight into the Mental Capacity Act 2005 & The Deprivation of Liberty safeguards. We observed notes from one person's file that clearly demonstrated that the provider was unlawfully restricting them in a number of ways.

The provider did not have effective systems in place to ensure that high quality care was achieved. The registered provider failed to offer supervision and training to staff to maximise their potential and improve standards of care.

The home did not have adequate systems in place to monitor people's weight and coordinate health care needs. This prevented health promotion for all the people living at the home being maximised.

Is the service caring?

Good

The service was caring.

We observed positive interactions between the staff and people. Staff were warm in their approach and responded when people needed help or assistance.

Summary of findings

Staff had a good knowledge of the people they supported. They understood the history and previous experiences of the people they were caring for and how that shaped their lives today. The staff understood people's needs and used non-verbal communication to maximise positive interactions.

Relatives and health professionals all agreed that the staff providing support at the home were caring towards the people living at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in planning their own care and preferences were sought when planning care from the individuals themselves. Care plans were person centred detailing people's routines and how they liked to be supported. However we noted people's preferences were not always followed on a daily basis.

We observed staff responding to people's individual needs in a timely manner. Staff were eager to meet the needs of people.

The people had limited relationships and friendships outside of the home. There was a lack of activities and lack of structure within the home. We observed people sitting around for long periods of time with no appropriate activities being offered.

Information was not always provided in an accessible manner. There was no evidence of the home using alternative communication aids to enhance communication. This meant that people living at the home did not always have access to information that would promote their independence and enhance their well-being.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have adequate systems in place to ensure that administrative records were maintained and stored securely and effectively. Files were incomplete or missing. The provider did not keep rotas to record which staff member had been on shift and timesheets for staff were missing or incomplete.

The registered provider did not have formal systems in place to allow staff time to reflect on work and share good practice.

Although there was evidence of internal audits taking place in relation to the environment, the provider had not consulted with other professionals, relatives and external agencies as part of their quality audits to seek external advice on how the service could improve. This meant that the service was not responsive to change and improvement.

Evaglades

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health & Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Heath & 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 was an unannounced inspection carried out over 2 days on the 8th & 9th December 2014. The 2 adult social care inspectors that made up the team visited the home, unannounced on 8th December 2014. The lead inspector returned to the home (announced) the next day to complete the inspection process.

The last inspection was carried out on 25th September 2013. There were no concerns identified and we found the service was meeting the legal requirements.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This 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. The provider did not return a PIR and we took this into account when we made the judgements in this report.

We also liaised with the Local Authority Contracts team and Healthwatch to obtain their views regarding service provision. Both agencies said that they had no information which suggested that there was any concern in which the home was managed.

Information was gathered from a variety of sources throughout the inspection process. We interviewed 4 staff members at the home. This included the Registered Provider, the Deputy Manager and 2 members of staff. We also spent time with one of the people who lived at the home to see how satisfied they were with the service being provided. We observed interactions between staff and people to try and understand the experiences of the people who could not verbally communicate. After the inspection we also spoke with relatives to discuss how satisfied they were with the care provided. We also discussed the quality of service provision with the GP who was commissioned to attend to the health needs of people living at the home.

As part of the inspection we also looked at a variety of records at the home. This included the care plan files belonging to the two people who lived at the home and two recruitment files belonging to staff members. We also viewed other documentation which was relevant to the management of the service.

We also looked around the home in both public and private areas to assess the environment to ensure that it was conducive to meeting the needs of the people living there.

Is the service safe?

Our findings

One person who used the service said that they liked using the service and that they felt safe there. Observations led us to believe that the other person using the service was comfortable and felt safe in the presence of the staff and the environment. Throughout the inspection we saw the individual in a relaxed state, smiling and laughing.

We also spoke to relatives who said that they were happy with the staffing and the service that was provided.

Because the home did not have a formal rota in place at the time of our first visit we asked the registered manager for a list of all the staff who worked in the home including casual staff. The registered manager produced a list which stated that there were 6 staff members and 1 volunteer employed by the home. When we asked to see the files relating to these staff, the staff member who was responsible for the administration of the home was unable to locate any documentation belonging to three of the staff names on the list.

Although people told us that they felt safe we found that people were not protected by safe recruitment of staff at the home. Effective systems were not in place to make sure that staff were only recruited who were safe and suitable to work with vulnerable adults.

Files checked did not contain all the information required to ensure safe vetting procedures were in place. One staff file did not have an application form or references. This meant that the individuals previous work history could not be checked or previous employers could give details about the individuals previous work history and work practices. Another file had an application form in place but there were unexplained gaps in their work history, which meant that the employers were not fully aware of what may have happened in a person's past history. This meant that the registered manager had failed to protect people from unsafe recruitment processes because employees past work history had not been thoroughly checked.

We asked to look at the Disclosure and Barring Service (DBS) records of all staff. DBS checks allow employers to check for criminal records belonging to all employees and potential employees to assess their suitability for the job role. DBS checks are a legislative requirement for all employees employed in a caring role. DBS checks were not available for all the staff. A staff member responsible for the administration of staff files told us that one casual staff member who worked at the home had worked for the company without the company obtaining a DBS check. The registered manager had relied on an old DBS that a previous company had carried out for the individual. This showed that the recruitment procedures at the home were not robust.

This was a breach of Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safeguarding training which raised people's awareness of what constituted abuse and how to report it had not been completed by all staff. Staff we interviewed were aware of what constituted abuse and the need to report it. However one member of staff said that they were unsure who they would report it to. The home had a policy and procedure in place for responding to abuse and staff were aware of this.

On our first day at the home, we noted concerns in relation to infection control and health and safety. Whilst looking around the home there was a smell of urine in one of the bedrooms. We asked the registered manager about this and they said that there was not usually any odours in the rooms. They assured us that it was because the room had yet to be cleaned. One of the other bedrooms we inspected had a dirty bathroom with a toilet in it that was stained and smeared with faeces. We inspected the rooms the next day and the rooms had been cleaned and the smell was no longer there. We discussed standards of cleanliness with the registered manager and were reassured that they would maintain the level of cleanliness.

On the first day of inspection we also noted that one of the bedroom windows on the first floor lacked any window restrictors. This meant that the sash window could be opened widely and presented a risk should someone try and climb out of it or fall through it due to the sheer drop on the other side. We mentioned this to the provider who had it remedied straight away. When we checked the next day a restrictor was in place to minimise the amount the window could be opened.

During inspection, staffing levels at the home were satisfactory. We observed staff going about their duties in a relaxed manner and always had time to speak with people and address any needs that they may have had at that

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particular time. This meant that the health and wellbeing of both persons was managed appropriately and in a timely manner. We observed people receiving support when they needed it.

The registered manager told us that there was a consistent staff team at the home. Because of this consistency the manager did not complete a rota on a weekly basis. This meant that it would have been difficult to demonstrate retrospectively who was working at the home on a given day or night. On the second day the registered manager had drafted a template rota to illustrate which team members worked when. The rotas showed us that the staff team consisted of a very small staff team working fixed shifts. Observations made at inspection confirmed that the staff on duty understood the individual needs of each person living at the home. The registered manager said that they did not use outside agency staff and the team covered for each other whenever someone is off sick or on leave to ensure continuity of care.

The home had a clear procedure in place for dealing with emergencies. The manager confirmed that they were on call should this be required. One of the staff members we spoke with confirmed that the registered provider would attend work to help out in an emergency. Training records relating to a staff member who worked at the home on an ad hoc basis showed that this member of staff had not received any formal training; as a consequence this meant the person may not be equipped to deal with emergencies.

During the inspection it was noted that people could not seek assistance in an emergency because rooms did not have call bells fitted. This meant that individual's health and well-being were at risk if they were unable to seek assistance when required. The registered provider said that all movements during the night were heard by the on call manager as they slept below the bedrooms. We discussed this area of concern with the registered provider who assured us that they would consider the risks we highlighted.

Although the provider had risk assessments in place they were not always up to date. Risk assessments are documents that identify and manage potential risks of harm or injury. We observed an environmental risk assessment that said it was to be reviewed in 2012 but this had not been done. Whilst looking around the home we identified risks from recent building works. These risks had not been addressed and included on the environmental risk assessment. The deputy manager said, "risk assessments did take place; they were often just done verbally rather than formally." This presented a risk as information relied on verbally can be forgotten, misconstrued or not passed on to the relevant person.

Risk assessments relating to the people who used the service were partly up to date and included a comprehensive list including topics for managing finances, managing an individual's mental health condition, activities and personal care. We observed that following an incident when one person choked, their risk assessment was updated accordingly. This allowed the staff team to be proactive in dealing with situations and helped to minimise any risks of the event occurring again. However, we also noted that another person's care plan and risk assessment had not been updated to cover all risks relating to them going out of the house alone. The deputy manager highlighted the risks associated with the person going out unsupported whilst being interviewed yet these were not recorded in the person's risk assessment. This meant that risks were not addressed in a timely or proactive manner.

We looked at records relating to fire safety and fire equipment. These records demonstrated that the provider carried out regular checks of all equipment and carried out regular fire drills. However a document relating to the procedure for checking emergency lighting showed that the provider was not following their own procedure and was only carrying out checks every 6 months rather than monthly.

The staff member responsible for environmental safety provided us with records to demonstrate that all gas and electrical tests were up to date. The staff member also had an up to date maintenance schedule. Which demonstrated that the registered provider proactively maintained the environment to an acceptable standard.

We observed medication being administered at the home. Medication was given in a very person centred way. Staff administering medication were aware of the people's preferences for taking medication. The staff member sought consent from the person before supporting them to take their medication. Staff were aware that the person had the right to refuse to take the medication. The right to refuse the medication was also covered in the persons care plan.

Is the service safe?

Training records showed staff received training prior to being able to administer medication. A staff member confirmed that they were not permitted to give medication before they had received medication training. Medication was stored in a locked cabinet, which was kept secure at all times. We observed the staff member who was administering medication checking the medication against the Medication Administration Record (MAR) sheet before administering it. This ensured that the correct medication was administered safely.

Audits were carried out monthly to ensure that all medication prescribed had been administered. All audits were signed and dated by the staff carrying out the checks. The MAR sheets showed that medication was signed for accurately and consistently after each medicine was administered. The deputy manager confirmed that the MAR sheet was kept in the persons file, when not in use. This ensured that a person's identity could be checked against the photograph on file before medication was prescribed, thus ensuring that the correct person received the correct medication.

Care plan files had a section containing patient information sheets for medications prescribed, however some patient information sheets were missing and others were in the files for medicines which were not currently prescribed. This meant that staff did not have efficient access to medication information in an emergency.

The provider had a policy on medicines that could be given by staff as a homely remedy. Homely remedies were pre-agreed by the GP and a list was kept in the persons file as to what could be prescribed without GP involvement. However records showed that the provider had not reviewed these medicines with the GP by the stated date. This meant that people were at risk of being administered homely remedies which may have an adverse effect upon other medications being prescribed by health professionals.

We recommend that the provider refers to the National Institute Clinical Excellence (NICE) guidelines relating to the administration of medication.

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered provider. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The registered provider confirmed that they had not attended any training looking at these legal requirements and during the inspection we found that people were being deprived of their liberties within the home. Through conversations with staff and evidence from within the care plans we identified that one person using the service was having their liberty deprived in several areas of their life. The individuals care plan demonstrated that particular items of clothing were being used as a restriction. Restrictions were also evident relating to visiting and also this person's liberty was restricted at times due to staffing levels prohibiting them leaving the building. The registered provider had failed to consider whether or not an application should be made to lawfully implement these restrictions.

The provider had also failed to keep up-to-date with the legislation. There was no evidence of any best interests meetings taking place to discuss these issues or any assessments to measure the person's capacity to make these decisions themselves. This meant that suitable arrangements were not in place for people to obtain valid consent.

The registered provider said that they always sought consent from people before providing care. During the inspection it was noted that people using the service did not have capacity to make all decisions relating to their life. However there was no information in the files as to how the provider made decisions when the person lacked capacity to make decisions. There was no evidence of any best interest meetings taking place to enable decision making to take place.

We spoke with two relatives of the people using the service and asked them if they were involved in decision making for their relatives. They confirmed that they were not involved in planning or making decisions in relation to their relatives care. This may mean that balanced decisions are not always reached when providing care for the peoples using the service as only the provider and staff make decisions on the person's behalf.

This was a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) regulations 2010.

Although staffing levels were adequate at the time of the inspection, one member of staff said that at times staffing levels on a day to day basis could lead to frustration. The draft rota we were provided with on our second day showed that for the majority of time there was only one staff member on duty to support the two people living at the home. The staff member said that person centred support could not always be achieved when there was only one staff member on duty to support the two people who lived there. The staff member said, "Sometimes we plan activities and then [the person] won't go out. We can't leave them on their own so [the person] has to stay in." We discussed it with the deputy manager who confirmed that their hours were flexible and that they would meet the extra staffing requirement as and when required. However as no rotas were maintained at the home it was not possible to ascertain if and when any additional staff had been working at the home.

Staff members we spoke with confirmed that when additional people came to live at the home staffing levels were reviewed and did increase. On one occasion whilst an individual came to stay for respite care the registered manager brought in an extra staff member to ensure that their needs were met.

The provider did not have formal systems in place to enable the staff to develop their skills. The registered provider confirmed that regular, formal supervisions do not take place. Supervision is a one to one support meeting between individual staff and a management team member to review their role and responsibilities. Staff confirmed that they did not receive regular supervisions or appraisals. The registered provider stated that they had forgotten to act on the findings from the previous inspection to formalise supervisions and assured us that they now had plans in place to formalise them. The registered provider said that staffing matters were dealt with informally,

chatting to staff as and when required. Staff confirmed that should there be any pressing matters to discuss the registered provider would just address them at that time. One member of staff said, "The registered provider will just tell me if I am doing a good job or not." Lack of formal supervisions prevents staff discussing any pressing concerns or difficulties that they may be having within their role and hinders them from reflecting on their role. It also means that without written guidance relevant information appertaining to care provision may be forgotten or misconstrued.

We looked at the training records of the staff at the home and found that comprehensive training was not provided to all staff. On the first day of inspection the registered provider said that they did not have a training matrix to collate all training details of staff. On our second day at the home the registered provider provided us with a training matrix of all staff training that they had developed over night but this did not have dates of completion or dates of expiry on it. When we compared the training matrix to the certificates held by the provider it was evident that the training matrix did not correspond with the training certificates available for all staff. For instance the registered provider informed us that all staff had up to date safeguarding training but certificates to verify this were not available for all staff. Training certification showed that provider had also failed to ensure that staff had completed training in food hygiene. Also staff who were tasked with additional roles such as such as Health and Safety lead had not received additional training to enable them to carry out the role effectively.

According to training certificates available, only one staff team member had completed any safeguarding training. No staff had covered any training in Mental Capacity Act awareness training. The lack of training in Mental Capacity and safeguarding had been highlighted at the previous inspection in 2013. The registered provider had assured us that they would take action and ensure staff completed the refresher training immediately. However, there were no certificates available to show us that the registered provider had completed this training as discussed previously.

The provider had one volunteer who worked at the home, who regularly covered the sleep over shift and provided on call provision to the two people at the home. We could not determine what training that this person had received as the training matrix showed that the person had received training in all the required areas. However the registered provider could not show us any certification to show that they had completed any training. This lack of verification meant that the people living at the home may be at risk of receiving inadequate care because staff were not trained.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010.

Staff told us that training at the home was good. One member of staff told us, "I have completed my NVQ 2 but the registered provider is putting me through my level 3 next year." The records available at the home did not demonstrate that this level of training was being undertaken and it was clear that training in other areas had not been completed.

We looked at one staff member's file who was newly appointed and it showed that they had undertaken a comprehensive training programme as part of their induction which covered the key elements and skills required to carry out their role as a support worker. This included safeguarding, safe administration of medication, fire awareness, health and safety and first aid training. All of these topics were covered in the first six months of employment.

The new worker also confirmed that they had undertaken a period of shadowing a senior member of staff at the beginning of their employment and was only permitted to work unsupported when the senior member of staff was confident that they were competent to do so. We also observed the new workers induction paperwork which consisted of key tasks that they had to undertake, under supervision by a senior member of staff prior to working alone. The staff member confirmed that they could only complete specified tasks once the management team had deemed them as competent to do so. This was signed off in the induction booklet by the staff member's provider to show that they were confident with the staff member's progress.

We looked at the daily records belonging to both people using the service and noted that the records kept were detailed and personalised and included comprehensive information regarding the individuals' health. However daily care records were not signed by the member of staff who had completed them and also included a lot of incorrect terminology or abbreviations. This meant that

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staff were not following guidance on national recommendations for record keeping. Having unsigned notes may mean that information inputted into personal notes cannot be traced back to the person who wrote them. This problem would be exacerbated because the provider did not keep rotas to demonstrate who had worked in the home and when.

Care plan records showed that health needs were sometimes met. Information about medical conditions were documented in notes. Staff worked alongside health professionals to address health problems on an on-going basis. Records were kept by the provider of visits to health professionals and included a brief outline of why they visited outcomes of the meeting and actions that were to be taken. We spoke with the individuals' GP, who confirmed that the staff at the home sought medical advice whenever it was required.

The provider had systems in place to respond to ill health but there was a lack of any systems in place for health promotion. The registered provider said that the people using the service had annual health checks but there was no documentary evidence of this in the personal files to demonstrate this.

Staff demonstrated that they could communicate effectively with people using the service. Both people had limited communication due to their learning disabilities. However the staff had a good knowledge of alternative ways to communicate with the individuals to understand their needs and preferences. We observed that staff communicated effectively by using appropriate eye contact and touch.

We spoke with one of the people who lived at the home. They said that the food was good and they were involved in choosing what they had to eat. We observed a staff member asking them what they would like for their lunch and they then proceeded to cook it for them. When people had finished eating the staff sought reassurance that they had had enough to eat and offered more if required. Staff told us that they had a loose menu which enabled them to plan what food to buy for the shopping on a weekly basis but they were flexible each day as to what was cooked. The menu could change according to the preferences of people. We observed lunch time and both people eating lunch were happy and relaxed.

One staff member told us that they recorded people's diets to ensure that they have a balanced diet. The member of staff showed us a completed menu diary which recorded what people had eaten that day. One person at the home had a care plan in place to ensure that they ate healthily.

A staff member confirmed that they offered the person guidance and informed choices when it came to choosing meals. They said, "If it was up to [the resident], they would have fish and chips every day. We try and offer alternative solutions, offering them other things that they like so that we limit the number of times they have fish and chips. We need to help [the person] watch her weight."

However there was no evidence in their file to show that their weight was logged. We asked the provider about this and they said "If we notice any changes in their eating or their health we will refer to the doctor straight away." The registered provider also told us that the doctor or nurse at the surgery weighs the individuals whenever they go. However there was no documentary evidence of any information being relayed from the doctors to the home that enabled the staff team to monitor the individual's weight.

Despite the provider recognising that people may be at risk nutritionally there was no evidence of any nutritional assessments in place for the people.

We observed drinks being offered readily throughout the day and staff were checking that the individuals had enough to drink. This showed that people's hydration needs were being met.

We spoke with the staff at the home about best practice guidance in relation to providing services to people with learning disabilities. The provider confirmed that they did not have any links with any external agencies that provided sector specific guidance. Consequently the staff had no understanding of personalisation of services and how services for people with learning disabilities should be developed and improved. There was a lack of emphasis based around planning individualised activities that promoted independence and empowerment.

We recommend that the provider consults with the guidance set by the Department of Health in relation to good practice for improving the lives and health of people with a learning disability.

Is the service caring?

Our findings

We observed positive interactions between the staff and the people living there. Although the people using the service had limited communication, staff used their skills to promote communication and interactions. We observed staff and people using the service laughing and joking with each other. This showed us that they were comfortable in each other's presence.

There was a stable staff team at the home and it was evident that the staff team knew people well. Staff had a good knowledge of people's histories and were aware of triggers that made people upset or anxious. We observed the registered manager consoling one person who was upset. The registered manager showed great empathy and understanding. The registered manager said, "I understand fully what it is like to lose your parents. It doesn't matter how long ago it was, it can still be raw. We just spend time with [the person] talking to them about it. We tried bereavement counselling with [the person] but it just made them more upset, so we just make sure we spend time with them now to talk it through and comfort them." This showed that staff had a compassionate manner.

On another occasion we observed a staff member reassuring a person who was upset. The staff member spoke to the person in a calming and caring manner and used appropriate touch to comfort the person.

We spoke with various people including relatives and a health professional to ask how they rated the care given by the provider. The health professional that we spoke with said "The staff are very caring." Relatives also reinforced that they thought the staff were very caring.

When we asked the staff at the home what they thought their achievements were, one member of staff said," We are caring. I am proud of the care that we give." Another staff member said, "Our visions and values mean that people living here get good care, we give the individuals' a good life."

Staff were very aware of the care needed by each person and responded to people in a timely manner. We observed one person coming into the room complaining that their hearing aid was not working. The member of staff on duty came to their assistance, found new batteries and replaced them immediately. This enabled the person to be more fully involved in conversation.

Involving people who used the service in decision making was dealt with at an informal level. People were supported to express their views and be actively involved in everyday decisions in their lives by the staff who knew them well. One staff member said, "I ask people about everyday events, I ask them what they want, it's something I do every day." Another staff member said, "We learn from what we think, from the way they act, their behaviours. If they wanted to go on holiday and it was only somewhere in Morecambe, if we thought it would benefit her, we would take them"

One staff member said that larger decisions such as going on holiday and buying clothes were left up to the registered provider to deal with. Staff would inform the registered manager when the persons needed new clothes and the manager would replace them accordingly. This means that the persons were not always fully participative in all decisions regarding their care.

The deputy manager informed us that they did not at present use any advocacy services. They informed us that one person used to go to an advocacy group but chose to stop going. The home had a poster on the wall displaying the local advocacy group and the contact number in the hall of the home. The registered manager said that they had not found the use of advocacy as necessary for the people living in the home. They said that they knew people well enough to know what they like and want but would not hesitate in contacting them if they felt that any of the persons would benefit from the service.

Because of the size of the service and the limited communication of the people at the home, the registered manager did not hold meetings with the people as a group. Wishes and preferences were sought on an individual basis through differing methods of communication. One staff member told us, "We just know when [the resident] is happy or unhappy with things. We can tell from the way they act."

Staff were aware of the need to promote peoples dignity and privacy. Care plan risk assessments covered privacy and dignity and noted that people may be at risk of not being treated in a dignified manner. The risk assessment recorded that staff must knock before entering rooms. One staff member told us, "I always apologise before I touch a person when doing personal care such as applying cream. I always knock when I enter rooms."

Is the service caring?

Both people using the service had space away from the communal lounge to enjoy their own privacy. The registered manager had developed a room for one person to use as their own private and personal space away from the main lounge. This allowed the person to spend time alone if they so wished. This space was used to keep all their personal belongings in as they did not like having these in their own room. We did not however observe the person being offered the right to use this private space during the inspection but the individual appeared relaxed and happy sat in the lounge.

The staff told us that they always promoted independence for the people however we failed to see this consistently happen during our inspection. One person's file stated that they enjoyed carrying out cleaning tasks but we observed staff undertaking all the tasks around the home whilst the person sat in front of the television. This meant that development of independence skills and preferences of persons were not always followed.

Staff were aware of the need to promote confidentiality. One staff member said, "It's about respecting people. I wouldn't go around talking about people to my friends and family." The provider ensured that confidentiality was discussed with staff as part of their induction and it was covered in the induction handbook.

Despite one person living at the home for a long period, the person still became anxious at leaving their possessions in their room unattended. We observed a staff member reassuring the person and telling them it was okay to leave their personal items in their room. The staff member offered words of reassurance confirming that their personal belongings would be safe. In turn, this reassured the person who then went and put items in their room.

Is the service responsive?

Our findings

Throughout the duration of the inspection people were not actively encouraged to participate in any activities. Staff were focussed on providing task orientated care rather than person centred care. One person was constantly sat in a chair in front of the TV. This confirmed a relatives concern who expressed dissatisfaction that their relative was never appropriately occupied. They said, "Whenever I visit they are just sat in front of the TV." The home did not have any structure for carrying out activities. The only exception to this was on a Monday when the people had a trip out with the registered provider.

The registered provider told us that they used to have external bodies visit to carry out activities with people but this no longer happened.

People using the service had limited relationships and friendships outside the home. There was no evidence that the peoples were supported to participate in any community groups or clubs. All activities partaken were very insular and only involved spending time with staff. This increases the vulnerability of each person as they only have contact with the staff team and have no independent people in their lives to monitor their well-being.

One person used to go to church. The registered provider said that they used to take them but the person chose to no longer go. The person now opted to sit at home and watch the church services. This was recorded on the persons care plan.

This was a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) regulations 2010

People were involved in planning of their own care. There was evidence that the people were involved and their preferences were sought throughout the care plan record. Care plan records were in place to guide staff on how to meet people's personal needs. Care plans were comprehensive and covered the person's preferences and addressed a wide range of topics including attending to personal care, activities, family relationships, mobility and hygiene. Care plans were regularly updated, reviewed and signed by staff.

One person's file contained a full section on how to best support the person in the morning. It included the person's morning routine and why it was important to them. The staff team was aware of this and the need to follow it. One staff member told us, "[they] like to have their bath in the afternoon. They are not good in the morning, so I always bath them in the afternoon. They get more from it and are more likely to do more for themselves."

Peoples care plans had information relating to the person's history. This enabled staff to have a good understanding of previous experiences which had shaped the persons behaviours, attitudes and thinking. Staff told us that they could empathise with people and understood why they sometimes acted in certain ways.

Although the staff implied that the people using the service lacked capacity there was no evidence of anyone outside the staff team contributing to care plans.

Although care plans detailed people's preferences we noticed that people's preferences were not always listened to. Care plans had details in them relating to peoples hobbies and interests. However we found no evidence to suggest that these activities took place. One person's file stated that the person liked assisting with tasks around the home including cooking, washing up and cleaning but we never witnessed them being offered the opportunity to be involved. In this situation the needs and the preferences of the person had not been taken into account.

We noted from one person's file that there had been a gradual decline in the person accessing community groups and activities. This had left the person socially isolated. There was no evidence in the file that the staff had addressed this with the community mental health team or any other health professionals to see if this could have been caused by a decline in the persons' mental health.

The provider told us that each Monday the people at the home go out for the day. It was evident that this was an established routine as one of the people came down the stairs with their coat, stating that they were ready to go out. The registered provider said that the people like to go out for lunch for the day. When we spoke with the person they said, "I like going to garden centres with [registered provider & staff member]"

The draft staff rota did not show flexibility for people to have one to one time to enable them to participate in activities of their choosing. The rota showed only one staff on duty carrying out support tasks during the day. However the deputy manager informed us that their hours were flexible and if one person wishes to go and visit their

Is the service responsive?

relative they would arrange staffing to do so. Another staff member confirmed that staffing was flexible and extra staff were called in when the person was going to visit their relative.

People did not always have information that they required in an accessible manner. Each person's personal file contained information on how to complain and included a section on the Care Quality Commission. This shows that the policy was out of date as CQC do not have the powers to investigate individual complaints. This information was stored in the individuals care plan file which was locked away and was in a written format. This made it inaccessible for the people using the service. This inaccessibility may prevent the individuals from being aware of their rights to complain and how to complain.

As part of our inspection process we asked to see the record log of complaints. The provider did not retain an official log. The registered provider told us that they had not had any complaints in the past 12 months. They reassured us that if someone should complain they would deal with it immediately. If it was something that they could not resolve then they would pass it on to someone who could, outside the agency.

One relative informed us that they had tried complaining to the registered manager about the service but did not receive a response. The relative was unhappy about the way they were treated by the provider as they felt excluded. They stated that they had complained to management but their issues were not addressed.

We spoke to one person who lived at the home and they told us that they were happy with the service they were receiving. We spoke to two staff and they had a good knowledge of how to deal with a complaint efficiently. One staff member said, "Firstly I would try and rectify it myself, if I couldn't deal with it I would go to the manager. If I felt it was relating to the manager I would go to CQC."

The registered provider assured us that they knew if both people were unhappy as they could tell from their behaviours and would act upon this. However there was a reliance on the registered provider and staff being open and honest and responding to the complaints. The lack of informal supports around the individuals living at the home means that there is a risk that their voices would not be heard should people have any complaints or are unhappy with the service.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Is the service well-led?

Our findings

The home had a registered provider in place. However at the outset of the inspection, the provider told the inspector that they had been ill over the past twelve months and stated that they felt that the service quality had deteriorated as a result. The registered provider insisted that the welfare of people using the service had not been affected by their ill health. The registered provider said that they had to rely on more people to assist their on a day to day basis to carry out their role. On the second day of our inspection the registered provider was unable to participate fully in the inspection as their ill health impacted upon their ability to attend.

The health of the registered provider has had a direct effect upon the administration of the service as records were out of date, disorganised or missing. Policies and procedures had not been reviewed by the stated date. Environmental Risk assessments were not up to date. Homely remedy sheets had not been reviewed. Poor systems of storage of records were evident. The deputy manager was unable to locate timesheets belonging to staff and DBS checks belonging to staff. The provider/manger did not have up to date, organised records in place relating to each staff member. We asked to look at staff files for temporary and volunteer workers. The deputy manager also failed to produce timesheets for staff at our request, stating that they could not find them at that time.

The deputy manager who was responsible for updating DBS checks for staff and timesheets belonging to staff. The deputy manager was unable to locate any of these documents and said that filing "was in a state,"

This was a breach of Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) regulations 2010.

The provider did not have effective systems in place to ensure that high quality care was always achieved. People at the home had not been formally consulted about their perspectives about service provision. The provider did not hold formal residents meetings to gain feedback and did not carry out annual surveys to gage satisfaction. There was no documentation present to demonstrate that people had been asked about the service and ways in which it could improve.

Similarly there was no evidence of any other quality audits being sought from other health professionals, or relatives which would assist the registered provider in improving the service. The deputy manager confirmed that they had not consulted externally with any of the key people involved in people's lives.

This was a breach of Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) regulations 2010.

The registered provider had failed to act upon previous assurances made to the Commission after the previous inspection in relation to providing staff with training related to safeguarding vulnerable adults and the Mental Capacity Act.

We discussed the culture of the service with staff. Staff were not encouraged to be empowered and contribute to the running of the home. Staff said that at times it was difficult for them to make suggestions about how to improve the service. The lack of team meetings prevented further opportunities for staff members to be involved in decision making. Had the provider facilitated regular team meetings staff members would have had the opportunity to discuss issues, express views and influence the development of the service.

Staff members stated that making suggestions to improve the quality of the service were often not well received. One staff member said, "Periodically I am listened to. I can make suggestions. Sometimes it causes friction between us but then five minutes later they [the registered provider] come around." Another staff member said, "Sometimes the manager takes it personally, it can be difficult to approach. The manager can be one visioned; It's hard to approach them, especially as they have been ill."

The provider confirmed that they did not have regular team meetings but information was shared on an as and when basis. This was because the team was so small and worked together on regular shifts where they shared ideas and thoughts.

We discussed audit systems with the deputy manager and found the management team did not have a clear picture of monitoring the quality of care delivery. Audit systems were in place to monitor the environment and the health and safety of the building but there were no processes in place to monitor the individual care records of people using the service.

The staff at the home shared the same vision and values for the home but these values were paternalistic and did not

Is the service well-led?

include promoting people's autonomy and independence. All the staff interviewed said that the vision of the home was to care for people and ensure they were happy. There was no discussion about building independence and empowering the individuals to become increasingly self-sufficient.

We spoke with a health professional who had previously visited the home to attend to the health care needs of the people who used the service. The health professional expressed concerns about the lack of leadership and poor management of the home. They stated, "This home is not very structured and is disorganised – staff are very caring but not organised - it is just the organisation that worries me at times".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered provider had failed to consult with the people living at the home, their relatives, health professionals or key stakeholders to receive feedback on the service being provided. The provider had failed to ensure that regular audits were undertaken to identify, assess and manage risks relating to the health and well-being of the people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered provider had failed to provide appropriate opportunities to allow the individuals to develop their autonomy, independence and community involvement.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered provider had failed to develop systems that allowed them to be confident that consent had been received from people in relation to their care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Action we have told the provider to take

The provider had failed to ensure that an appropriate system was in place for identifying, responding and managing complaints made by people using the service or people acting upon their behalf.

Regulated activity	Regulation
	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered provider had failed to maintain, retain and store staffing records and records relating to the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered provider had failed to operate safe and effective recruitment procedures to ensure that the staff employed were suitable to work with vulnerable people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered provider failed to implement suitable systems to ensure that staff received regular supervision & appraisal to enable them to reflect on their role, discuss any potential problems that they may be experiencing and develop personally. The registered provider failed to offer staff the opportunity to meet together as a team, discuss their work and reflect on service provision.

This section is primarily information for the provider

Enforcement actions

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