The Royal National Institute for Deaf People

Harding House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Harding House on 26 and 31 August 2016. The inspection was unannounced on the first day and announced on the subsequent day. This was the first inspection of the service since it had registered with a new provider The Royal National Institute for Deaf People.

Harding House is registered to provide accommodation and personal care for up to for up to 10 people who are hard of hearing with mental health needs. The building is owned by a separate landlord who is responsible for any repairs to be carried out in the service. At the time of the inspection there were eight people living in the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe using the service. Staff had received training and understood how to keep people safe from abuse. Prevention measures had been put in place to minimise future re-occurrences of risks to people's welfare.

Information about the home was not accessible and people who used the service told us they were not understood in their own language. People's rights were not always respected and staff did not always provide person-centred care.

Recruitment checks were completed to assess the suitability of the staff employed. Staff had not received suitable training to enable them to carry out their roles effectively. There was not a suitable number of staff deployed to meet the needs of the people who used the service.

'As required' medicines and stock checks were not safely managed and the cleanliness of the communal areas of the premises were not properly maintained. The storage of medicines was managed safely. Staff had received annual medicines training.

People were supported by staff to attend health care appointments when there were changes to their health care needs or associated risks to their health. Good food hygiene practices were not followed by staff working in the home.

People's privacy and dignity was respected. People made their own choices about their care and support, and health and social care professionals were involved in these decisions. People told us staff did not treat them with respect. Advocacy support was not always used to ensure people were listened to and their concerns acted on.

Quality assurance systems were not in place to effectively improve the quality of care delivered. Feedback was not sought from people or their relatives to obtain their views regarding how the service was run.

People were supported by staff to attend health care appointments when there were changes to their health care needs or associated risks to their health. Staff followed the legal requirements in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Care plans had not been thoroughly reviewed to ensure people's care needs were met.

People were involved in activities in the wider community but told us they not socially stimulated whilst using the service. Some people were not confident any concerns they raised would be resolved. There was an easy read complaints guide available for people. Relatives told us they knew who to report concerns to.

We found four breaches of regulations relating to safe care and treatment, dignity and respect, person centred care and good governance. You can see what action we asked the provider to take at the back of the full version of this 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.

Information was not accessible so people may not have known who to report any concerns to if they felt unsafe. People's medicines were not always managed safely. Staff had not received regular competency checks in respect of medicines.

There was not enough suitable staff available to meet people's needs.

The building was not well maintained to ensure people's safety.

Staff understood what abuse was and knew how to report concerns if required. People told us they felt safe. Risks to people were assessed to make sure they were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to maintain a well-balanced diet and good food hygiene practices were not always followed. Staff had not received appropraite training to communicate effectively with people.

The legal requirements in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were followed by staff.

Staff supported people to visit health care professionals to ensure their health care needs were met.

Is the service caring?

Requires Improvement

The service not always caring.

People told us they were not always treated in a respectful way. People's care and support needs were not consistently met. Advocacy was not readily available.

People were given choice and control over their care needs and

health and social care professionals were involved in this.

People's privacy was respected. People had completed specific care plans and their wishes were recorded in these.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Relatives were not involved in care reviews and did not receive feedback about their family member's care. People's care needs were not clearly recorded and assessed and not detailed to support staffing delivering care in accordance with people's needs and preferences.

People had access to activities that were important to them outside of the home but some people felt care staff did not have time to spend with them.

People and their relatives were given the opportunity to raise any concerns, but some people were not certain if these would be resolved.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager did not carry out regular and consistent audits and to improve the service. Feedback was not sought from people who used the service or their relatives.

Staff were kept informed about matters that affected the service. The registered manager kept the Care Quality Commission informed of any incidents that occurred.

Harding 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.

We inspected Harding House on the 26 and 31 August 2016. The inspection was unannounced on the first day and announced on the second day. The registered manager was on leave and was unavailable on the first day of our inspection but returned for the second day of our inspection. During the first day of our inspection the deputy manager assisted in their absence.

The inspection was carried out by two inspectors on the first day and one inspector on the second day. Because all the people who used the service were deaf we were also accompanied by a sign language interpreter on the first day. British Sign Language (BSL) is a language in its own right, with its own grammar and syntax and does not conform to the structure of the grammatical English language.

Prior to our inspection we checked information that the Care Quality Commission (CQC) held about the service which included a Provider Information Return (PIR), previous inspection reports and notifications sent to CQC by the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We spoke with five people who used the service, four relatives and a healthcare professional .We contacted the local authority and spoke with two health and social care professionals to discuss any information they held about the service. We spent time observing the care people received and toured the building.

We looked at five people's care records including their medicines records. We also spoke with one senior support worker, three support workers, the deputy manager and the registered manager. Additionally we viewed five staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

People were not always protected from avoidable harm as their medicines were not always effectively monitored. We looked at four people's medicines records and found that staff did not always follow safe practices when administering PRN (as required) medicines. For example, some people were administered medicines such as paracetamol for pain relief. We looked at the medicines administration records (MARs) in people's files over a period of two months and found that in three people's files they were given 'as required' medicines. However, the reason why the medicines were given was not recorded. In one person's file, we saw that on three separate dates in August 2016 medicines were administered but the reasons for this were not recorded on the MAR. Within the second person's file, we saw that on two separate dates in August 2016 medicines were given and not recorded in the MAR. In the third person's file, we found that on two separate dates in July 2016 medicines were given, and the reasons were not recorded. We checked the stock count for 'as required' medicines and found that for one person there were discrepancies between the number of tablets recorded following a stock count and the actual number in the 'as required' medicines boxes.

A recent medicines audit was completed by a member of staff, however the audit had not identified the medicines errors we found. The staff member had signed to say that all medicines had been checked and were correct. We spoke with the member of staff and deputy manager regarding this and they acknowledged that errors had been made. Training records demonstrated staff had completed medicines training; however only two care workers had completed competency assessments to ensure they had the skills to manage medicines safely. Therefore the provider could not be assured that staff were competent to safely support people with their medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were delivered to the service in (Bio-dose) packs on repeat prescriptions and held in a lockable medicines cabinet, which only the appropriate staff had access to. Bio-dose is a monitored dosage system that contains liquid and solid medicines. There was patient information for each person that contained an accurate description of the medicines that were being administered. We looked at the MARs for people and found that administered medicines correlated with the staff signatures. People's medicines records included a photograph to identity who the medicines had been prescribed for, date of birth, GP details and any allergies or reactions people may experience. Some people who used the service self-administered their medicines which were stored in their rooms in a locked cabinet and each person kept their own key to the cabinet. People signed their own medicines charts to say whether or not they had taken their medicines, and staff understood when and how to report the refusal of medicines and any errors. We found that people's medicines had been consistently reviewed by health care professionals

During our inspection we viewed the building and found that some areas of the home had not been thoroughly cleaned. On the second floor we saw there was a rusted sanitary bin in the communal hallway, opposite the communal bathroom, and a staff member told us that one of the people using the service sometimes put this in the hallway. We pointed this out to the registered manager who informed us that the

person on the floor did not use these adaptations, however this response did not take into account visitors to the home, or people who had limited mobility needs. In the utility room located on the ground floor there were discarded mop heads and used dishcloths' on top of the washer/dryer. Items such as mops and buckets were in the corner of the room, and this area was generally unclean. This meant that good infection control was not monitored to ensure that people who used the service received safe care.

Following a fire safety inspection on April 2016 we found that the provider had completed three out of the four of the actions that were recommended by the Fire Safety Officer. One of the actions stated that the provider must review their fire training and must ensure all employees receive six monthly fire training for day staff and three monthly training for night staff. We found that the six monthly training for day staff was in place, however the three monthly training for the night staff was not completed. As all the staff were expected to do sleep-in shifts this meant that all employees would have to receive fire training every three months. We spoke with the registered manager regarding this who disagreed with the fire safety officer's recommendation regarding the three monthly training and said they would address this directly with the officer. This meant that people who use the service, staff and visitors were not sufficiently protected against the risks of fire.

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

We saw that some areas were poorly maintained. In the first floor bathroom the toilet seat was loose and the staff member told us this had been reported to the landlord to be replaced. The windows in the bathroom could not be opened as the decorator had accidently painted them shut. We checked to see if the ventilation fan was working and we saw that it was. We checked to see if the ventilation fan was working and we saw that it was. The carpet area near the utility room was worn with a large burn mark and near the exit at the back door was a dried area of damp. We viewed the cellar which was kept locked to ensure people's safety, and we saw there was a large patch of damp on the wall in one room and the wall and floor was wet. We looked at records in relation to the health and safety management of the home. We found records to show that the damp, loose toilet fitting and the windows in the bathroom had been reported to the landlord. The registered manager told us the landlord did not respond swiftly to the repairs that needed to be carried out, but would follow this up again.

The second floor of the home was clean and tidy. Fire tests and drills were carried out and individual personal emergency evacuation plans (PEEPS) were recorded in people's care plans. The home was fitted with the appropriate aids and adaptations so people could be alerted in the event of any emergencies, this included vibrating pads under the pillow to wake a person, and different coloured lights flashed in each room to donate the emergency and to inform people someone was ringing their door bell. To ensure the home was kept safe for people, professional maintenance and servicing of equipment was routinely carried out, including regular water temperature and legionella checks to ensure the safety of people's health and wellbeing.

There was not a suitable amount of staff deployed to meet the needs of people who used the service. This had an impact on people being supported with the preferences that were important to them outside of the home. For example a relative told us, "I rang to ask when my family member was coming to visit me and the staff member told me they could not attend the visit with [family member] because they are short staffed due to the holidays." This meant that some people were not supported to visit their relatives when they chose. We spoke with three care workers who confirmed the staffing levels were insufficient. Comments included "Generally enough staff are on duty, but at the moment no, because one staff is off [on authorised leave] the staffing team is depleted", "We are short staffed", "There is not enough staff, I have been asked to

come in and do extra shifts it almost becomes necessary to be flexible most of the time they use relief staff" and "For now we are short, one left last month, the recruitment is in process." We viewed the rotas and saw there were two full- time positions that were due to be filled. To accommodate this, the provider used relief staff or alternatively the staff team were asked to work extra shifts. There were two deaf staff who worked for the service, however one of the staff was a relief worker and we were told they were due to leave the service in September 2016. The registered manager and the deputy manager told us they were holding interviews for candidates on the 30 August 2016.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff recruitment files, which contained background checks that had been obtained before each person started work. We saw that the documents included two references, evidence of the person's identity and employment history. Criminal records checks were carried out on all the staff before they began working in the service to ensure people's safety.

People told us they felt safe and comfortable using the service and their relatives echoed this. People commented, "I like my key worker, I'm safe here", "Safe enough but it's so boring", "I really like living here for a long time, because I want to know how to make new things in the future" and two relatives told us, "I've only been once as I am unwell, when I saw [my family member] she/he did not seem unkempt or uncared for and looks clean," and "My [family member] really loves their independent flat, we had a phone line put in and we text her/him regularly."

There was an easy read policy folder that had been signed by staff and eight people who used the service in January 2016 on bullying and harassment and safeguarding people from harm, and we saw this was discussed in meetings with people. People who used the service had completed easy read safeguarding questionnaires that included picture symbols. The questionnaires showed they had been asked specific questions on how to identify and recognise different types of abuse. There was guidance on how key messages in the policies should be relayed to people; which included the use of role play and drama. However, the easy read policies were located in the staff office on the shelf and not accessible to the people who used the service. Additionally, the easy read policy did not contain pictures or contact details of who people could report their concerns to, such as the registered manager and the head of service. This information was left blank. This meant that people would not be aware of who to report their concerns to. The registered manager agreed to place a copy of the folder in the communal areas of the home or in people's rooms and to update the folder.

There were systems in place to reduce the risks of harm or potential abuse. There was a safeguarding policy that guided staff as to the correct steps to take if they had a concern and staff knew how to access this. All of the staff had received safeguarding adults training. The registered manager informed us that if any concerns were identified they would act on these and refer any allegations of abuse to the local safeguarding team and to CQC. We spoke to a health care professional during our inspection who described the preventative measures staff had put in place to minimise the likelihood of harm for a person. They were complimentary about the support the person received from staff when their behaviour became challenging to the service.

Staff were familiar with the whistleblowing policy that gave clear guidance and advice about who staff could report to in the event of any concerns they wished to raise in the workplace. We spoke with staff who understood how to whistle blow if they had a concern that they wanted to report about the workplace. The contact information included a whistle-blowers helpline, the Care Quality Commission (CQC) and other organisations such as Public Concern At Work.

Risk assessments for people were detailed and informative and included control measures that had been introduced to reduce the risk of harm to people. This included assessments relating to people's finances, health and wellbeing, people's mobility needs and social stimulation. We found there were risk assessments in people's care files to support staff understanding of behaviour that was challenging and identify ways of supporting behaviour change.

The provider had systems in place in the event that a person needed to be reported as missing. People's care plans contained relevant information to give to the police; such as a photograph and a physical description of the person and their communication needs. When accessing the community people carried mobile phones, and one relative told us that because their family member had limited writing skills, the use of predictive text was perfect for them. People also carried identification cards that informed people they were deaf and how best to communicate. For example, if people could lip read they could show their card so that people knew to look at them when speaking or that they may need to write something down. We saw there was a signing in and out book and board in the communal area and we observed that some people did not always use this. We asked staff how they were alerted when people were missing from the home and they told us they always regularly checked the premises and rung people's door bell's if they were not seen during the day. This showed the provider had systems in place to ensure people were safe when accessing the wider community.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to follow a well-balanced diet. We saw that one person had attended an appointment to see a dietitian. They were provided with an action plan which included a list of foods to remind the person what they could and could not eat, and of their dietary goals. We looked at the person's food cupboard on the ground floor and observed this could not be located by the registered manager because the food cupboard did not have names or symbols on them. This could cause confusion for people looking for their own possessions and food. We asked the registered manager whether the plan was being followed, however they could not find any information. There was a black and white newspaper article on the communal noticeboards regarding the need for awareness of salt and sugar content in food, however the article was dated 2013, furthermore the articles were written with a high level of text. This was not displayed in an easy read or pictorial format and meant that the information would not be understood by people using the service. People were not always supported to follow good food hygiene practices. We examined the communal kitchen on the first floor of the home. We looked in the fridges and found food items such as milk and vegetables were out of date and needed to be discarded. Meats and dairy products were left uncovered and not labelled with the date of opening. Meats were not stored separately from other foods in the fridge. If food is not cooked, stored and handled correctly, people can become ill with food poisoning and infections from cross contamination. Therefore the provider was not protecting people from avoidable harm related to food hygiene practices. We spoke to the care worker who told us the person who lived on the floor was independent and cooked their own foods, and did not like staff touching their foods. However, we saw no evidence that staff were supporting this person to understand and manage these risks.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We examined the kitchens on the ground and second floor and found these areas to be clean, food items were stored appropriately and labelled. Food hygiene notices were displayed in the kitchens in large print and picture symbols advising people of the do's and don'ts, for example, there were guidelines on how to use the microwave and the disposal of perishable foods. We found on these floors that good food hygiene practices were followed, fridge and freezer temperature checks were completed daily, and food items were stored appropriately, sealed and labelled with the dates they were opened. Daily cleaning rotas were displayed on the kitchen noticeboards which showed that people were supported by staff to keep areas of the home clean. Some people were supported to cook their meals and others were able to cook on their own. People told us, "I do cooking myself, I do enough cleaning, I'll get the washing done", "I'm learning how to cook food" and "I like the staff, they help me. They help me with food." One relative told us, " My [family member] would eat chips, burgers and pizza's all day long if he/she could, that's their choice, and will not engage in sitting down with people for meals due to their health needs. However, it can be very easy to leave him/her to their own devices."

We spoke with staff regarding people's foods and they told us they supported people with a Sunday dinner and to prepare all the foods. The senior care worker told us, "It's part of the person centered planning to ensure we meet those needs, for example, [person's name] and the dietitian, he/she has to do half an hour

of exercise daily and record their intake in a food diary. We support him/her to do that and support them to understand what has been asked." We looked at staff training records and saw they had completed up to date training in food hygiene.

There was not a suitable number of sufficiently trained staff to meet the communication needs of people who used the service. People told us they could not understand staff and what was being explained to them and because of this they were frustrated, "Sometimes they don't understand, I don't always get what they're talking about. They don't understand sign language", "It feels messy, frustrating and confusing. It's different, talking about doing things and it confuses me.", "They're hearing they talk to you, well I'm Deaf, I work hard to understand they talk amongst themselves. I show and sign not just speak" and "I tend to lip read I would prefer it if they were better. It's to do with risk." One person explained how a member of staff had got the orientation of a sign incorrect, "It varies, you have to make things work we can't all be angels." Another person said, "It's always the same people, same, same, I'm trying to teach some of them to improve their sign. I'm teaching staff, some staff have their own thing sometimes they're talking and just tell me, I do it to get it over with." One person told us loudly, "You need to teach them to learn to communicate using BSL sign language." People had various ways they communicated including BSL and staff members should have the ability to communicate clearly with people in respect of all their communication needs.

This also had an impact on people having a clear understanding of their rights and responsibilities using the service. One person said, "Outside it's good, but inside it's only alright. My bedroom I should paint it, there are rules about it I'd like to paint it different colours. I don't know if I can, I asked, they said I could do something but I wasn't quite sure" Another person reported, "I think they'd disagree with a significant relationship." A third person commented, "I go out with Deaf people so I sign with them." The senior care worker said, "We don't help them as well as we could, social networking, budgeting skills, improving their communications. We don't have that level of skills, so we just repeat ourselves. They get more and more frustrated, it's important for their wellbeing." We saw in the training matrix that staff had completed training in relation to supporting people in respect of supporting people with such as core and safe practitioner training.

British Sign Language (BSL) Level three is an advanced level used for those who work on a regular basis with deaf people and would enable staff to communicate with people at a complex level. Of the staff we met four were hearing and two were deaf. All staff could communicate using BSL up to Level two, however none communicated at Level three. This meant that people who used the service were not able to be fully understood in their own language.

The training records we looked at showed that staff had been trained up to BSL Level two, however for one member of staff their training certificate was not available. The support worker stated they were trying to locate their records, therefore we could not be certain if the staff member had completed their training. We looked at the job descriptions for the provider and saw the requirement for the role was for candidates to be competent in BSL Level two. Furthermore, on viewing the job description for the senior care worker we saw that they were required to be competent in BSL Level one. We discussed this with the registered manager who explained this was an error and said they would clarify this with their Human Resources department. We spoke to staff who told us they were keen to achieve their BSL Level three but were waiting for the provider to confirm if funding was available for this.

Staff told us they received regular supervision and appraisals and we saw records to confirm this, however one staff member had not received regular staff supervisions.

The above issues constitute a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulation 2014.

The registered manager had advised staff to bring in all their training certificates from the courses they had attended with the previous provider. This was to ensure the provider could update their training records and identify areas of training that were required. Staff had completed an induction, training in risk assessing, managing falls, emergency first aid, understanding learning disabilities, diabetes awareness, substance misuse and mental health awareness. Staff had also received specialist training on positive interventions to support people who behaved in a way that challenged staff. This was tailored to the individuals using the service and gave staff the skills to diffuse situations and reinforce positive behaviours when people may behave in a way that put themselves and/or others at risk. Team meetings were held every month to give staff the opportunity to discuss best practice regarding how to support people and any areas of concern.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager confirmed that no one in the service was subject to a DoLS authorisation. Our conversations with the staff demonstrated that they understood and were trained on their responsibilities under the MCA and DoLS arrangements. We found care records showed people had been involved in discussions during their Care Programme Approach (CPA) meetings regarding their capacity about specific decisions. CPA meetings are used to ensure that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. People had been offered the choice to consent for their life stories to be shared and we saw that one person had chosen not to and this decision had been respected by staff.

People were supported by staff and health and social care professionals to maintain good health. One person said, "I'm never ill, I was before I was here, I go with staff before my [relatives] came" and another person commented "Staff come with me, I have an appointment soon, they'll help me with things like coughs, they phone the GP and I stay in bed." There were separate files for people that contained information and appointments that people had attended to address their health care needs. We found that staff supported people to attend appointments with a range of healthcare professionals including audiologists, GPs, dentists, opticians, community psychiatric nurses and dieticians. On the first day of our inspection we observed a care worker supporting a person to attend a hospital appointment. We viewed the appointment letter and saw that an interpreter had been arranged to help with the person's communication needs. We found that one person was at the risk of falls and the discharge planning meeting focussed on the use of aids and adaptations that were put in place to manage the person's safety. Hospital passports were completed so people could show these to health professionals when attending hospital appointments. These documents contained information on, for example, how best to communicate with the person, how he or she showed pain, and the best way to give medicines. This meant that health services could make reasonable adjustments to ensure that they are able to meet the health needs of the people using the service. One support worker told us, "Even with the shortage of staffing levels at times, we never miss people's health appointments. Healthcare services must provide interpreters and they do, as we will not interpret for them, particularly as something as important about their health."

Requires Improvement

Is the service caring?

Our findings

People told us that they were not always treated with kindness and respect by staff. One person said, "They say I'll stay until I'm old and grey and they're quite rude about it. The staff don't respect us they say 'go on, off you scoot.' The staff are dismissive I was involved, but what's the point. The staff [over there] I don't like, they do nothing for me. No help from them, I ask them but they go off and do what they do, remove space we leave each other alone." Another person told us, "There are no new ideas, sometimes you see staff and you ask, 'no, it's private, off you go." And a third person reported, "They're ok, sometimes it feels chaotic. The staff change so much I just deal with it myself, it's just easier, staff are good but it's messy. I prefer it to be one staff who I know I'm going to, it feels like being told off at school."

Staff told us that some people were independent and required limited support with their care needs. However staff made assumptions that people were fully independent and generally we saw that people were left to carry on with their day. One staff member said, "I organised a visit, now it's up to her/his relative. I need to check first, and [person's name] will keep us in touch about her/his [family member's] health." We spoke to the relative who told us they had not been able to contact the staff at the service. We asked staff about people's road awareness and being able to manage their own finances and one staff member said, "Oh, they can manage all that." However we found that some people had their finances managed by the local authority and another person needed support with their bills. One relative told us their family member disliked travelling on certain types of public transport. This showed that staff did not have a good understanding of people's individual care needs and preferences.

Advocacy support was not accessible for people who used the service to ensure they were represented and supported to make decisions. For example, we saw in one person's file that they required help to understand their employment rights, and needed more time with an interpreter to explain this. However, there were no records to show this had been acted on. The staff explained the importance of advocacy services particularly for the residents' meetings and to obtain impartial feedback about how the service was run. The senior care worker said, "To run a residents' meeting, we have to rely on the Deaf staff, and we only have two at the moment." We saw hand written minutes of residents meeting to show that these had taken place to obtain people's views. A relative told us their family member had signed a placement contract, regarding the responsibilities of the home, but did not have a clear understanding of what they were signing. They addressed this with the operations manager and this was resolved. We spoke with the registered manager regarding advocacy who explained they had access to the local authority advocacy service and had emailed an officer to establish a link with the service in July 2016, however this had not been followed up. This meant that people's views were not always listened to and acted on.

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

Some people made positive comments to us about the staff. One person said, "[Care worker] is my favourite I think he/she cares, staff understand me they do listen, it's OK." Other people told us, "Some staff look nice and talk to me about some things" and "Staff listen they're alright. I write things down." Relatives told us,

"The staff are nice they want people to be happy" and "Staff are generally chatty and pleasant when I have seen them."

People made their own choices about their care and support and health and social care professionals were involved in these decisions. One person had made the decision regarding the management of their medicines and we saw records to show this would be monitored regularly by the community psychiatric nurse and the GP. On the day of the inspection we saw that a health professional had arrived to support a person to view another home they would like to move to in the location of their choosing and another person told us about the type of clothes they chose to wear. Care profiles were in place so people could tell staff what was important to them and how best to support them with their interests and preferences. For example, one person had stated that they wanted support to attend a gym and another wanted help to prepare food, and we saw this was acted on. One person disliked doing domestic tasks and instead was given the option of feeding the resident cat. Relatives told us there were no restrictions to prevent them visiting their family members and some people visited their friends frequently. One person told us, "I have friends who I visit; I go to church on Sundays," and another person said, "I go out and meet my friends. I sort myself out, I stay in touch with my [relatives]."

One care worker had worked in the home for numerous years and had a good understanding of people's needs. They explained that because deaf people communicated and observed body language and facial expressions much more astutely that hearing people, eye contact was an important aid when communicating with people. Furthermore, it was essential for staff to observe this and be able to recognise people's triggers that may cause their behaviour to become challenging to the service or when they experienced a change of mood or emotional distress.

Relatives told us that their family members were supported with their personal care and appearance. We observed staff respecting people's dignity and privacy. We saw that staff rang people's door bells before entering their rooms. One care worker told us, "We had end of life training and have done end of life care plans and it's picture based with visual choices." We looked at the specific care plans and found that people had been involved in producing them.

Requires Improvement

Is the service responsive?

Our findings

Relatives informed us they had not been involved in care reviews, and they did not always receive feedback. One relative said, "One thing is staff never call me back. I always pick my family member up to come when they want to visit, he/she wants to go on holiday and I wanted to discuss this with them, but I never hear from them they don't return my calls. I have not been involved in any meetings to talk about my family member I'm not sure if they have a care plan." Another relative said, "I rang the home to see if my relative was coming to visit me, it took three weeks for the staff member to return my call, and I have to call them to ask about [family member], the staff tell me he/she is ok, alright, they are going to the gym, but nothing about their health." A third relative commented, "I never get any information about my family member, if I ask how my [family member] is doing, they tell me everything is Ok, I get nothing. From my point of view if a relative rang up I want some form of communication, I'd like some answers. My family member texts me sometimes and tells me he/she goes to college, but no one ever tells me anything. In the past the hospital has given me feedback, and I would always get answers like any [family member], I don't even know who his/her social worker is." We saw people had relationship maps in their files, and this included the names of the relatives and friends who were important to them, however we found there were no written records to show that people had been asked if they would like their relatives to contribute to their care plans or review meetings. This meant that people's relationships with their relatives were not always recognised or valued.

Three people living at the home could not recall being involved in decisions about their care. "I don't know about medication, I get tablets to help. I ask for help, you need to talk to staff." Another person said, "There's various ones, they might be mine. I'm not bothered. Some things have been written down, I want to do the English course, I don't know if they have been signed." We looked at care plans and found them to be inconsistent and incomplete regarding the care that was provided to people. For example, in one care plan we read that the person required support with their English grammar but their communication chart was blank. One person told us they would like to move closer to an area where their family members and significant other lived. We saw that a placement review had been held but the information was not in the care plan or recorded in the daily notes. In a third file, we found there was chart in place for staff to monitor the person's health need and we found there no records to show this had been monitored between August 2015 to June 2016. This meant that outcomes for people's care and support needs were not being met. Documents from the previous provider were being used in people's files. The registered manager had informed the care workers in a team meeting that all staff must archive documents that contained the previous provider's documentation, but this was not completed.

We spoke with staff regarding people's individual care and support needs and they told us they were assigned to keywork people and attend monthly one to one meetings to check on people's progress. We crossed referenced these meetings in two people's care files and found there were gaps in these meetings from February 2016 to June 2016, in another file we saw that meetings were not attended for February, April and May 2016. Where people had refused to attend these sessions we could not find records to show why they had not attended. When we asked staff about the records, they told us they could not comment because they did not keywork that person and were not responsible for their care needs. We observed that the senior care worker kindly offered to support a person with their appearance and discussed this with their

keyworker who disagreed and said dismissively they are not the person's keyworker and should not be involved. A relative told us, "I spoke to a staff member who told me the keyworker was not in and they could not help me as they was not the keyworker and would pass the message on, what if the keyworker was on annual leave or sick who would help then?" This meant that people did not always have assistance from staff to ensure their care and support needs were being met.

People's personal preferences regarding specific gender care was not met. People were not always supported by staff of the same gender if requested. One person said, "I used to go to hospital, it's better with male staff. But it's even better to support myself, there's much more women staff." We spoke with the registered manager regarding the recruitment decisions to meet people's diverse needs. They explained the provider would be recruiting for specific gender staff and deaf staff to accommodate people's individual needs

People engaged in leisure activities outside of the home, some people told this they did this independently, but some people told us they were bored and the staff were too busy. People said, "We have a giggle. It's easy to giggle, but they're busy I go out with Deaf people so I sign with them. "I go out, by myself to different places, I go to the theatre, to the shops. I'm not bothered about deaf club. I like doing things by myself, a while ago I watched a game. I'd go on my own, here is boring and I'm stuck here I'm pretty confident and I can do my own thing", "I go out so I'm less bored, it can be noisy here sometimes", "In two weeks' time I'm going to the pub, I'm saving up the money. When I have enough I'll go to the pub and meet deaf people." , "I go to the park, when it's hot I do laundry on Wednesday. On Tuesday it was too hot. [In the deaf club] there's a tea and coffee group with sandwiches," and "I'd like to move but I'll stay for now. Better here for now, I'm happy enough but there's room for improvements."

The activities in the home were based on supporting people with independent living skills, such as supporting people to clean and assistance with cooking skills and two people enjoyed gardening. However, there were no records to show when people attended these activities. We found that in people's rooms there were leaflet holders with information on their care plans but there were no easy read service user guides in place to inform people about what to expect at the service.

The above issues constitute a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Care plans were presented in a manner that people would find easy to understand. There was information about what was important to each person, how to keep people healthy and safe, how to give people recognition for an accomplished task and their likes and dislikes. One relative told us they attended a review with their family member's keyworker to discuss their progress and make suggestions, however the family member had chosen to refuse the choices they had been offered. Another relative had been invited to a review of a person's placement but was unable to attend. Staff had supported a person to buy clothes and a gift to attend and celebrate a special occasion for a family member.

People told us about their recreational pursuits, interests and hobbies outside of the home including attending the deaf club, college courses, exercise classes, shopping and one person was employed part-time. Another person said they had finished a college course and were looking to enrol again this year, but would like to seek employment. A staff member told us they supported a person to attend college and an interpreter was required, however funding was not available for an interpreter and a note taker. The person's relative explained they stopped going to college, and the care worker consistently encouraged their family member into other areas of education and employment. One person gave us permission to view their room and we saw this was comfortable and personalised with belongings that were important to them. We

saw a staff photo board with their names and pictures, so people could identify the staff who were on duty. There was a notice board located in the office informing staff of people's daily activities, such as healthcare appointments, attendance at the gym and going to view a property. There was a large garden with a pond and a shed used as a smoking area, and we observed one person watering the flowers, the person told us, "I decided I wanted to make it look nice." Staff told us how people enjoyed looking after the garden, including one person who had assisted in building some of the garden furniture. The following day we saw that gardeners had attended to work on the maintenance of the garden.

Two people told us they were unsure if anything would change if they did complain and one person told us they would discuss any concerns with the registered manager. A relative told us they had made a complaint and the registered manager had listened to their concerns and acted to resolve this. Another relative told us they had concerns regarding the lack of communication but had not raised a formal complaint, but would know who to speak to if they did. There was an easy read complaints guide available for people and was accessible on the communal noticeboard. There was a suggestion box in the communal hallway of the service, however we saw there was no sign on the box to inform people what the box was used for. We found there was one complaint that had been raised and this was acted on and resolved.

Requires Improvement

Is the service well-led?

Our findings

People told us they thought the registered manager was good but could not communicate effectively with them. People said, "He works downstairs in the office, there's always someone there, he comes and goes, I like him, he's a nice man, he can't really communicate," "Good, but sometimes he's a bit moody, it would be nice if he was a bit happier", "He's good he sorts out the money, he's dealing with that. He helps me with money,", "He's ok, he comes but I'm not bothered with him" and "He's a nice man."

We found that quality assurance systems were not always carried out and were inconsistent. Regular audits of the medicines, care plans and staff supervision were not carried out thoroughly by the provider to address inaccuracies and review risks associated with people's well being. For example, care workers supported people in the community and worked alone during the night, however there were no up to date lone working risk assessments completed. Formal questionnaires had not been sent to people, their relatives and health and social care professionals involved in their care and support, to obtain feedback about the service to assess the quality of care in order to drive service improvements. This meant that systems were not effectively monitored to improve the quality and safety of the services provided to people. The registered manager acknowledged this and agreed to address this.

The registered manager told us they had joined the service in April 2015 to manage the transfer of services from the previous provider and became the registered manager for two services in August 2016. They were further supported by the deputy manager. The deputy manager assisted in the absence of the registered manager. On the first day of the inspection; however we found the deputy manager did not have good knowledge of the systems and processes in the service. We spoke to the registered and deputy manager regarding this and they told us the deputy manager was based at the other local service and planned to integrate the services. This was to ensure a more consistent approach for staff to work more effectively together between services. For example, the use of joint team meetings. The registered manager said, "The agenda is an open discussion, and asking colleagues to be more open with each other and sharing feedback." The registered manager and the deputy manager were trained in BSL level one, which meant their communication with people who used the service was limited. They told us they planned to complete BSL Level two to ensure their communication was more effective.

One staff member described the registered manager as supportive, "[Registered manager] is much better than the old manager there's been a lot of changes, he listens to us and gives us support he never says he'll do it later he managed the TUPE." Other staff members told us they were happy the current provider was a deaf organisation and felt supported. However, one staff member told us the registered manager required more training in understanding the issues that deaf people face in their daily lives, and another told us they felt the providers' processes were inconsistent and did not feel supported. The registered manager acknowledged this and agreed to seek to resolve this with immediate effect.

The above issues relate to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.
We saw that a staff training quality audit had been completed to highlight staff training needs. The

registered manager told us their operations manager planned to visit the service to check how it was running and conduct regular audits. One relative spoke positively about the provider and the staff and told us they were impressed by the way the service had improved. Staff were flexible in their approach to work, for example, one member of staff swapped their day off to help assist the registered manager with the inspection.

Daily handovers were recorded by staff after each shift and included the handover of keys, medicines and finance checks and staff observations. Staff said that they were kept informed about matters that affected the home through team meetings, the communication book and talking with the registered manager. The most recent staff meeting minutes were available and detailed any changes regarding the home. For example, the grounds in the garden needed to be levelled out and we saw that a contractor had arrived to complete this on the day of our inspection.

The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: Service users were not always treated with dignity and respect and their independence, autonomy and involvement in the community was not always supported Regulation 10 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks to ensure the proper and safe management of medicines, maintaining the suitability of premises and detecting and preventing the spread of infections. Regulation 12 (1) (2) (b) (c) (d) (e) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and

operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: There was not always a sufficient number of suitable qualified staff and staff were not always supported to obtain further qualifications appropriate to the work they performed. Regulation 18 (1) (2) (a) (b)