Jeesal Residential Care Services Limited

Heathers

Inspection report

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Date of inspection visit:
01 May 2018
02 May 2018

Date of publication:
20 November 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 May 2018 and was unannounced.

Heathers provides accommodation and support to a maximum of nine people with a learning disability or autistic spectrum disorder. It does not provide nursing care. Accommodation is provided in nine self-contained apartments. Each apartment has a bedroom, living room, kitchen, and bathroom. On the day of our inspection there were nine people living at Heathers.

This type of care service should be developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy. Our inspection findings identified a lack of conformity with the Building the Right Support and Registering the Right Support guidance. Details regarding non-conformity are detailed in the body of the report.

There was a manager in post who was completing the registration process with the Commission. 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.

At our last comprehensive inspection on 12 July 2016 we found that the service was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and rated the service as Good.

During this inspection we identified that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for safe care and treatment, consent linked to the Mental Capacity Act, safeguarding people from abuse including depriving people of their liberty, good governance, staffing levels and training.

Full information about CQC's regulatory response to any breaches of regulation found during inspections is added to reports after any representations and appeals by the provider have been concluded.

From this inspection, on 1 and 2 May 2018 we identified areas of concern in relation to staff training in safe management of medicines, cleanliness of the environment and infection prevention control impacting on the care people received.

The service did not have robust governance processes in place for monitoring standards and quality of care provided. Staff did not complete clinical audits in areas such as medicines management and environmental condition and this was reflected in our findings during the inspection.

Staff did not consistently recognise the need to report safeguarding concerns or submit notifications relating to incidents to CQC.

Staff were not up to date with the provider's mandatory training or annual performance appraisals.

Staff approach and people's records demonstrated a lack of adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Low staffing levels impacted on people's access to meaningful activities, particularly in the community. Planned staffing levels recorded on rotas were not an accurate reflection of actual staffing levels on each shift.

People had choice of food and fluids, with support in place to shop and participate in food preparation. Staff treated people with care and compassion.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's wellbeing and safety were not always identified or actions taken to minimise and mitigate risks.

Medicines were not robustly audited with low completion of staff medicines training and competency checks.

The cleanliness of people's apartments did not mitigate the risk of the spread of infection by cross contamination.

Is the service effective?

Inadequate

The service was not effective.

Staff were not up to date with the necessary training for their roles.

Staff did not receive annual performance based appraisals.

Staff did not assess people's mental capacity or document best interests decisions.

Staff did not know if people had authorised Deprivation of Liberty Safeguards in place to lawfully restrict their movements. This was an infringement on people's human rights.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The condition of the care environment was not conducive to provision of high quality care.

We received inconsistent feedback from relatives about the care and treatment, the staff team and the service that people received.

We observed people were treated with kindness, respect, dignity and compassion during the inspection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not consistently link to risk assessments, with guidance for staff to follow in relation to the management of clinical risks such as use of physical restraint and safe access to household items.

Staffing levels impacted on people's engagement with activities onsite and in the community.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight and quality audits in relation to areas such the condition of the care environment, administration of medicines, consistent completion of people's daily written records.

No staff had up to date performance appraisals.

The management team did not actively encourage feedback from staff, people or relatives to drive improvement within the service.

Heathers

Detailed findings

Background to this inspection

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

The inspection was prompted by concerns received through the anonymous whistleblowing process; information shared by health care professionals and commissioning bodies. This inspection examined these concerns and identified other areas of risk while on site.

This inspection took place on 1 and 2 May 2018 and was unannounced. The inspection team consisted of one CQC inspector, and one CQC medicines inspector on the first day. On the second day of the inspection, there was one CQC inspector.

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. We also looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with five people who lived at Heathers. Due to the healthcare conditions that people were living with, some people were unable to tell us about their care. We observed care and support being delivered in communal areas and we also spoke with the relatives of four people and ten members of care staff including the manager, deputy manager and director of community services.

We reviewed six people's care plans in detail, nine people's daily records which contained behavioural charts, cleaning records, food charts and environmental safety checks. We looked at nine people's medicine administration records (MAR) and the medicines management procedures in place. We examined two people's Deprivation of Liberty Safeguards authorisation paperwork. We spoke with one visiting independent advocate. We attended the morning shift handover meeting on the second day of the inspection. We looked at four staff recruitment files as well as training records. We also viewed a range of

policies and procedures in place for the running of the service.

Inadequate

Is the service safe?

Our findings

During our inspection in July 2016, we found the service was safe and was rated Good in this key question. During this inspection, we found the service was not safe and we rated this key question as Inadequate. This was because of the poor quality of risk management and care plans, the condition and maintenance of premises, low completion rates of medicines management training and competency checks, poor standards of infection control and cleanliness, poor quality of shift handover and communication, inconsistent adherence to lone working policies and procedures.

People using the service told us they felt safe living at Heathers, however one person told us they would like alarm buttons so they could get staff support overnight. We received mixed feedback from relatives regarding the safety of people living at Heathers. Two relatives raised concerns about risks associated with people who experienced behaviours that challenge. Relatives raised concerns that people could be unsafe either at risk of being harmed by another person living at Heathers or from staff needing to attend to incidents leaving people alone and therefore at risk.

People had risk assessments in place, which contained guidance and techniques to follow when working with people with physical health care or behavioural support needs. Risk assessments did not detail least restrictive approaches or reflect in depth knowledge of each person to encourage participation in their daily routine as information was out of date. We identified contradictory information when cross referencing between risk assessments and care plans. Examples included inconsistent details of whether people required one to one or higher staffing levels for support while on site or in the community. We found discrepancies, making it unclear if a person experienced seizure activity or not. We identified differences between an emotional and behavioural care plan, indicating risk of verbal aggression, yet the corresponding risk assessment indicated risk of using weapons.

The service's statement of purpose stated that risk assessments should be reviewed and updated following incidents, but this was not happening in practice. We did not feel assured that risks were robustly managed or mitigated, placing staff and people at risk.

We found examples of care plans identifying people at risk of consuming household items and substances. We found some laundry rooms unlocked, with the doors open giving access to cleaning products and tins of paint. Some bathrooms contained razors. The deputy manager closed laundry doors while we walked round the site. However, we were concerned that appropriate action had not been taken to recognise or protect those people, identified as being at risk, from harm.

Staff recorded people's weights monthly in a shared diary, with one person weighed weekly. People had food record sheets when identified as being at risk of self-neglect through reduced food intake. However, we found multiple gaps in recording of food consumption. Staff did not consistently record reasons for missed meals. Each person required support from staff to maintain safe levels of food intake, incomplete records did not enable staff to accurately monitor people's nutritional intake.

People had care plans identifying individual needs relating to their health and wellbeing. However, these did not consistently contain dates to indicate when written or when they were due for review. Care plans included guidance on supporting people living with autism and behaviours that challenge. However, due to the lack of reviews, it was unclear whether the information was up to date and accurate.

Staff supported people with completion of personal care tasks, and checked the condition of people's skin as part of this process. Staff told us they would complete body map paperwork recording any marks, bruises or skin injuries as part of the monitoring process. Care plans contained guidance for staff to safely support people with eating and drinking to prevent risks of choking and aspiration. However, for people at risk of choking, their care plans identified that staff had training in first aid therefore knew how to respond in an emergency. However, there were low completion rates for first aid training. This did not offer assurance that staff had the skills or training to recognise and respond to choking risk incidents. It also, did not guarantee staff with the correct training would be working on each shift.

The service had a system in place for recording incidents, for example about medicines errors, but there was no system in place to ensure incident forms and follow up investigations were properly overseen by the manager to monitor for trends and taking further action when required.

Some relatives raised concerns about the management of people's medicines and the staff's understanding of medicines and their side effects. From reviewing people's medicine records, the information about individual medicines was not always accurate and up to date in line with most recent prescriptions.

We noted that when medicines were given to people, records showed they were not always given in line with written care plan information. Some guidance for medicines given as required (PRN) was confusingly written, increasing risk of errors.

Some people had medicines given crushed and hidden in food or drink (covertly). This approach was used for some people with limited mental capacity to make decisions about their care and treatment. We also found examples of its use where people regularly declined medicine. Assessments of people's mental capacity to have covert medicines had either not been completed or staff worked to out of date assessments, with no recent review. Best interests decisions about giving medicines covertly recorded a consultation with the GP, but not with the person's advocate, relatives or with the pharmacist. By not seeking advice from a pharmacist, staff had not obtained advice on compatibilities of preparing and giving people their medicines in food or drink.

Staff involved in giving people their medicines had not received training, with only 30% of senior staff completing the training. In addition, no staff had received competency assessments to ensure they managed people's medicines safely. We noted that the hard copy of the medicine policy available for staff to refer to was out of date and not in line with the most recent electronic version.

The service had not considered the risks around the security of medicines when delivered to the service or when needing refrigeration. The service had a plan to replace the storage units for medicines in people's apartments as these were old and in need of modernisation.

Some relatives reported concerns regarding the condition of people's apartments and hygiene standards, with an example of people running out of toilet paper and hand soap.

Staff did not complete environmental safety audits, for example infection prevention and control, checks of the condition of the care environments inside or outdoors. This was reflected in the overall condition of the

apartments, increasing risk of the spread of infection.

Heathers was visibly unclean throughout, with some unpleasant smells and odours including some bathrooms smelling of urine. The role of day and night care staff included maintenance of cleanliness throughout each apartment. Where appropriate, staff offered people support to complete household tasks while maintaining overall responsibility for hygiene standards.

Cleaning records for each apartment contained gaps in the completion of cleaning tasks, particularly overnight. Managers did not monitor completion of cleaning records, or complete spot checks on the condition of each apartment. We found examples of dirty bathrooms, damaged kitchen flooring, dirty walls and skirting boards and exposed plaster. Some floors were damaged and unstable to walk on following water leaks. It was unclear if these floors had been checked to ensure structural stability after the leaks. The overall condition of people's apartments impacted on the comfort of living environments for people, and an increased risk of the spread of infection through cross contamination.

Staff were responsible for monitoring fridge and freezer temperatures to ensure food was stored safely. Staff were meant to label food once opened and stored in the fridge to ensure items were disposed of once out of date. Staff completed temperature checks of food cooked on site, to ensure food was thoroughly heated. We found gaps in recording of fridge, freezer and cooked food temperatures. We found inconsistent use of food labels. People living at Heathers needed staff to complete these tasks to maintain their safety. This did not offer assurance that staff consistently maintained good food hygiene standards.

The service did not hold regular staff meetings, which impacted on sharing of lessons learnt and implementation of changes to practice mitigating risk of reoccurrence from incidents. Meaning that lessons were not learn or improvements made when thigs went wrong.

The above information meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was unable to provide an up to date electrical safety certificate. There was an in-date fire safety audit completed by the local authority, however, certificates for fire safety checks including alarms and emergency lighting were out of date. Staff told us the service planned to start completing regular fire drills, but they could not produce a record of past safety drills. Window restrictors were in place to maintain people's safety while having the windows open in their rooms on the first-floor.

The service had a legionella water safety certificate. Staff completed regular water temperature safety checks and flushing of the water system. The service could not provide evidence of descaling items such as shower heads. Water temperature checks in some bathrooms and shower rooms gave readings indicating inconsistent safe temperatures to prevent risk of scalding. We identified examples of water temperature readings of 45 degrees. There was no evidence that this risk had been identified by the management team. In one of the bathrooms with a high temperature reading, there had been a recent incident where a person had accessed the bath and run water without staff supervision. Fortunately, the person had not sustained injuries. We escalated our concerns relating to the risks of high water temperature readings to the manager and director of community services while on site. We were not given an indication of what would be put in place to address this risk.

We identified some uncovered, rusty radiators in bathrooms and living areas of the apartments, as well as uncovered water pipes. The heating was not on at the time of the inspection, but when in use there would be an increased risk of people burning or scalding themselves. We requested for these risks to be addressed

as a matter of urgency. Following on from the inspection, we received dates for when works would be completed to address these risks.
Most apartments contained furniture such as wardrobes and chest of drawers that were not secured to the wall or floor. This increased the risk of furniture falling or being pulled on top of people. Staff gave examples of where people had pulled over heavy furniture when experiencing behaviours which challenge. We observed some people who moved rapidly around their apartments, with furniture visibly moving. We requested for the service to secure all furniture as a matter of urgency following the inspection. Following on from the inspection, we received dates for when works would be completed to address these risks.

Some relatives told us having gravel in the car park made it difficult for people with mobility issues to walk over. Staff and relatives told us the gravel was a risk as it could be used as a weapon to damage property or harm people. Staff gave examples of incidents where cars and windows were broken by people using the gravel.

Some kitchens were accessible to people without staff supervision. One kitchen had a partition gate, but this was not kept locked therefore did not mitigate the risk of people accessing items such as the cooker and kitchen equipment. Electric hobs took time to cool and did not have covers to protect people from risk of burns and scalds.

Prior to the inspection, we were alerted to incidents where the service did not have heating or hot water in place. This impacted on safe care for people, particularly management of personal hygiene and maintaining safe body temperature. Staff told us that one person had suffered urine skin burns due to poor personal hygiene during this time. Staff confirmed medical input was sourced to address this issue. A backup heating system was being installed to prevent the risk of a reoccurrence but was not operational at the time of the inspection.

The above information meant the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives raised concerns around Heathers' management of safeguarding concerns and investigations, we shared this information with the local authority safeguarding team after our inspection. Staff we spoke with demonstrated a clear understanding of safeguarding practices and procedures, and recognising types of abuse. However, completion of the service's mandatory safeguarding training for adults was 16% and for safeguarding children as the site allowed child visits, was 11%. This did not offer assurance that staff consistently knew how to keep people safe.

We examined staff rotas and found that planned staffing levels were not a true reflection of actual staffing numbers on shift. Staff told us they worked as a team, with the manager and deputy manager working as care staff to cover gaps in a shift, and ensuring people received consistent standards of care. Staffing levels did not ensure people had the required level of support in place (e.g. one to one support or higher), during the day or overnight. Gender mix of staff resulted in some female's using the service receiving care and support from male staff. The manager identified the need for a risk assessment to be completed in relation gender mix on shifts to safeguarding people and staff, but this was not in place at the time of the inspection.

Staff and relatives identified concerns regarding regular incidents of low staffing levels and the impact on time spent with people, particularly for accessing community activities. Guidance from the director of community services to staff was for people to remain on site if there was insufficient staff to provide support in the community. This meant that people did not always have the opportunity for meaningful activity during the day, and this resulted in people displaying certain behaviours that challenge, due to a lack of

stimulation.

On the day of the inspection, two staff did not arrive at the start of the shift. To enable a person to attend a hospital appointment, and for another person to attend an activity the manager stood in to fill staffing gaps and provide the required level of support.

Due to low staffing levels, some staff worked alone with people during the day and overnight. Managers advised staff had radios to access support from colleagues, for example in an emergency. On the first day of the inspection, we observed that the three radios allocated for staff use were on a shelf in the senior staff office, and not with staff in line with lone working practices. Allocation of radios was not discussed during shift handover.

Staff told us staffing levels could impact on their ability to give people their medicines. This was due to a lack of trained staff on site, for example, agency staff had not completed training to the required standards so could not dispense the medicines.

Each person had a personal emergency evacuation plan in place for use in the event of an incident such as a fire. These contained clear guidance for staff.

Staff demonstrated understanding of accident and incident reporting procedures. We saw examples of investigations completed post incident by the management team, and the written responses provided.

Supporting information was available for staff to refer to when giving people their medicines. There was photographic identification with each medicine administration record (MAR), and information about medicine sensitivities (allergies).

There was person-centred written information about potentially sedative medicines prescribed to assist people with their psychological agitation and details about ways that staff could attempt to avoid having to give people these medicines.

Employment records examined did not consistently contain references, copies of proof of identity documents or evidence of Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) being undertaken before new staff started work. This helps to ensure people's safety by employing staff who were suitable to work in the care sector. However, the director of community services sourced confirmation of missing documents directly from the organisation's HR department and shared these with us after the inspection.

Inadequate

Is the service effective?

Our findings

During our inspection in July 2016, we found the service was effective and was rated Good in this key question. During this inspection, we found the service was not effective and we rated this key question as Inadequate. This was because of a lack of adherence to the principles and recording of Mental Capacity Act assessments, a lack of awareness of which people had authorised Deprivation of Liberty Safeguards in place, impacting on people's human rights.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records and DoLS authorisation paperwork examined demonstrated staff did not work within the principles of MCA.

Care records did not contain decision specific MCA assessments, or examples of best interests decisions involving relevant professionals and family members in relation to aspects of care such as consent to treatment. Staff did not understand the five principles of the MCA, or recognise the importance of least restrictive practice and balancing decision making relating to risk against people's wishes and preferences. Some staff confused powers under the Mental Health Act with their responsibilities under the MCA. Examples of where MCA should have been recorded included where people declined their medicines, were unable to manage their own finances or understand their own care and support needs. Care plans were not person-centred to reflect staff knowledge of people's individual care and support needs.

The management team were unable to confirm which people had authorised DoLS in place, or if these had any restrictions attached to them. Each person's apartment had a locked front door, opened using a key fob. Staff held the key fobs, and the system was overridden in the event of a fire. People needed to ask staff if they wanted to go out. When we visited each apartment, some people were locked in apartments on their own. Other people had patio doors open during the day, under staff supervision. Without the relevant DoLS authorisation in place and associated MCA assessments, we could not source assurance that people's movement was lawfully restricted. This was an infringement of people's human rights. We escalated our concerns to the manager and director of community services and requested this issue to be addressed immediately. Following on from the inspection, we received confirmation that the manager had liaised with the local authority DoLS team and submitted new application paperwork.

Archived folders contained examples of DoLS paperwork, which expired in February 2016. The management team were aware people's DoLS authorisation status was unclear, but had not taken steps to address this, such as contacting the local authority to seek further clarification.

One person received support from an independent advocate. Not all people had support from relatives or friends. We suggested for managers to educate staff to consider sourcing support for people when needed through independent advocacy services.

The above information meant the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Employment records and feedback from staff identified that staff did not have up to date annual appraisals or provision of regular clinical supervision. Supervision offers staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs. The service held its first senior care staff meeting the week before the inspection, with provision of supervision training.

Training figures indicated that staff did not consistently complete the provider's mandatory training including role specific courses. The service accessed training through on line and face to face sessions. Courses with low completion rates (ranging between 11% and 61%), included safeguarding adults and children, management of challenging behaviour, moving and handling, medicines management and signalong (communication), restraint and self-protection (NAPPI), mental health training, positive behaviour support planning, infection prevention control and pressure area awareness.

New staff completed the Care Certificate as part of the induction process; the Care Certificate is a set of induction standards that care workers should be working to. Training figures for the overall completion of the care certificate was low (31%).

The service maintained a training matrix, recording staff completion of courses and dates for refresher training and updates. Many courses were highlighted as overdue, or never completed. This did not provide assurances that staff had sufficient training to support them to meet the demands of their job role to provide effective support to people. Nor were we confident that the management team had recognised that the staff training levels were too low to ensure that staff were properly trained to be able to carry out their tasks.

Staff worked up to 12-hour shifts, with no planned breaks. This risked loss of alertness when completing one to one support. There had been a recent episode of staff found asleep during night shifts. The management team advised that staff spent time with people watching television or eating therefore felt staff had breaks. Low staffing levels on shifts further impacted on staff accessing regular breaks.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with staff, some identified that they would benefit from completing training in end of life care.

We observed staff preparing and serving people their evening meals in their apartments. Staff offered support, assisted and encouraged people to eat and make food choices. Staff told us they planned meals and shopping trips in consultation with people to offer choice and control over their menus. Some staff told us they ate with people to role model behaviours and offer social contact. People needed prompting by staff to access drinks and snacks throughout the day, and would otherwise be at risk of malnutrition and dehydration.

People had care plans in place for the management of eating and drinking, we found gaps in the recording

of food and fluid intake. The service made onward referrals to speech and language therapists and dieticians in consultation with the GP to source specialist advice and assessments for people. Prior to the inspection, we received concerns in relation to staff not following specialist advice provided by a dietician. During the inspection, we were unable to find evidence to support these concerns.

Staff gave examples of support offered to people to aid healthy living through food choices and encouraging increased levels of exercise.

Staff supported people to visit the local GP surgery and hospital appointments as needed. The service had accessible vehicles, some owned by people living at Heathers. Staffing levels permitting, access to vehicles enabled staff to support people with attending appointments and community activities to prevent social isolation.

Some relatives raised concerns regarding the condition of the unmade road leading to Heathers and the impact this had on the ease of accessing the local community, as well as the service. Some relatives raised concerns in relation to staff's response to medical changes in people's presentation, and timeliness of accessing medical advice.

We identified that the postcode for Heathers did not take you directly to the site. The manager identified that they gave an alternative postcode to emergency services such as ambulances. This could impact on speed of emergency response. The service was in the process of registering for an alternative postcode. As an interim measure, we suggested consulting with emergency services to ensure they knew how to find the service, and that the alterative postcodes were included in the emergency response protocol for staff to consistently follow.

Apartments were not wheelchair accessible and, due to the steps and stairs in situ, reliant on people being able to walk in and out of their apartments with minimal staff support. The properties would not be suitable for people with complex physical disabilities.

The manager and deputy manager attended professional meetings, and review meetings linked to people's Mental Health Act aftercare services. Staff told us they experienced difficulties with communication and engagement with some health and social care services impacting on ease of working relationships and timeliness of addressing issues for people.

Requires Improvement

Is the service caring?

Our findings

During our inspection in July 2016, we found the service was caring and was rated Outstanding in this key question. During this inspection, we found the service was not consistently caring and we rated this key question as Requires Improvement. This was because the condition of the care environment was not conducive to provision of high quality care.

From observations of staff interaction with people, staff treated people with dignity, care and respect and were familiar with each person's likes and dislikes. We observed staff knocking on apartment doors before entering.

Care plans did not adhere to the service's policies to support staff with management of people's dignity in relation to protected characteristics including religion and sexuality. Staff told us poor communication, and people's records not being regularly updated following incidents or medical reviews had resulted in staff working with out of date information.

People gave limited feedback on the care they received. One person said, "Yes," when asked if carers were kind to them. Another person said, "Yes," when asked if they liked the carers. Some relatives gave praise for the care and support given by staff. Some relatives told us they felt low morale within the staff group impacted on care given to people. Two relatives gave examples of where staff had spoken about incidents and difficulties experienced by other people, impacting on people's privacy and confidentiality.

We saw staff position themselves to be at eye level with people when speaking with them. Staff called people by their preferred name, and adapted their communication techniques and approaches to accommodate people with communication and sensory difficulties. Staff gave reassurance and emotional support to people when they showed signs of distress or feeling unwell. However, we identified that not all staff knew how to use alternative communication techniques such as signalong, impacting on ease of communication with people.

Staff encouraged people to maintain contact with their relatives with telephone calls when their relatives did not live locally. Relatives told us they spoke with care staff regularly by telephone, but received inconsistent levels of detail, and did not always feel assured that staff were familiar with people's care and support needs. Some relatives told us staff drove people to their family homes so they could spend time together.

The manager and deputy manager worked regularly with people to manage low staffing levels. This assisted them to become familiar with each person's care needs. The service did not have mechanisms in place to source feedback from people or their relatives on their experiences of using the service, and suggested areas of improvement. The service was reintroducing the key worker scheme to improve communication between people and the management team, but this was not in place at the time of the inspection.

We received inconsistent feedback from relatives on their relationship and communication with the

managers. Some relatives identified that all communication was by email rather than face to face, which they said made it feel less personalised.

Care plans did not demonstrate how people or their relatives were involved to maintain choice, control and involvement in their care and treatment. Staff did not record discussions regarding care plans with people and their relatives to ensure inclusion of opinions in the development of their plans; or collecting feedback through quality audits.

People had personal effects in their bedrooms and choice over what to watch on television or what music they wished to listen to. However, due to risks of harm to self or property, some people had to ask staff to change the channels because staff held the remote control.

Staff supported people to manage their personal hygiene and continence to maintain their dignity. Where people declined to wear continence pads, staff gave examples of approaches used to maintain personal hygiene and comfort.

Staff supported people to maintain their personal appearance and presentation, and encouraged people to make their own clothing choices. However, we noticed one person who was up, reportedly washed and dressed in the morning, but smelt strongly of body odour. This could impact on dignity particularly while out in the community.

Care plans indicated people's individual preferences for showers or baths. Care plans indicated some people were at risk of self-neglect in relation to their personal hygiene and presentation. The condition of the care environment, particularly the condition of people's bathrooms impacted on comfort and did not encourage people to use them.

Requires Improvement

Is the service responsive?

Our findings

During our inspection in July 2016, we found the service was responsive and was rated Good in this key question. During this inspection, we found the service was not consistently responsive and we rated this key question as Requires Improvement. This was because of the lack of a collaborative development of care and support plans, and discrepancies between care plans and risk assessments. People were not consistently able to access community activities. The service did not source feedback from people or their relatives.

Many care plans were out of date, and not regularly reviewed. Care plans were not collaboratively written with people and their relatives. Plans were not consistently person-centred or holistic referring to areas of personal importance such as people's spiritual and religious needs. The documents did not demonstrate involvement from people and their relatives to incorporate their personal preferences.

Care plans did not consistently link to risk assessments, with anomalies in document content. The service was working on reviewing and updating the care plans and risk assessments at the time of our inspection, but the old documents were being used by staff for guidance in relation to the management of clinical risks such as choking and behaviour that challenge. This placed staff and people at risk of incorrect procedures being followed or risks being overlooked.

One person's personal, behavioural support plan recommended use of physical restraint when de-escalation techniques were not effective. Staff reported to have used restraint once, but due to needing five members of staff, the approach was not feasible. This plan needed urgent review to ensure staff knew what process to follow, and to keep staff and all people at Heathers safe. This matter was escalated to the manager and director of community services during the inspection. These risks were not addressed by the management team during the inspection.

Care plans did contain documents indicating people's strengths and what people admired about them, however these were not up to date to reflect recent achievements.

Staff were responsible for one to one activities, and trips into the community. Low staffing levels resulted in people not always being able to maintain personal hobbies and interests, particularly those available off site. Relatives told us they sourced activities for people due to a lack of action by staff. Relatives said they felt changes in people's behaviour was linked to a lack of stimulation.

The service had received recent complaints and we saw written responses were sent to the complainant following completion of internal investigations. Information on how to make complaints was not accessible for people living at the service. For example, it was not available in a pictorial format that would be easier for them to follow. Relatives told us they knew how to complain, we received variable feedback on satisfaction levels with the handling of their complaints. The service statement of purpose contained information on the complaints process for people's relatives to follow.

Some staff told us they would be comfortable to raise concerns if identified. However, some staff said they

would not feel comfortable to escalate concerns for fear of reprisals. Staff based this opinion on past experiences and observations of their colleagues' experiences. There was a need to improve openness and honesty within staff culture.

The service did not hold community or relative engagement meetings; therefore, people were not offered the opportunity to give feedback or share their experiences. This was not in line with the service's statement of purpose.

People did not have care plans in place indicating their wishes and preferences when needing care at the end of their life. Staff demonstrated discomfort discussing this topic with people or their relatives. We would suggest provision of end of life training, designed for staff working with people with learning disabilities and autism.

Inadequate

Is the service well-led?

Our findings

During our inspection in July 2016, we found the service was well-led and was rated Good in this key question. During this inspection, we found the service was not well-led and we rated this key question as Inadequate. We found poor governance systems in place, with a lack of organisational oversight of the standards of care provided.

The service did not have systems in place to collect and analyse feedback from staff and people using the service. This feedback would lead to improvements in the service. The lack of team meetings meant staff did not have a forum for discussing concerns.

The service did not complete clinical quality audits in areas such as completion of care plans, infection control, medicines management, accuracy of nutrition and behavioural recording charts. Managers did not complete spot checks during the night to monitor standards of out of hours service provision or checks of the care environment.

Staff shared limited risk information during shift handovers. As staff worked in individual apartments, some staff worked alone for long periods during a shift. Cross over, support and sharing of detailed information was therefore required at shift handover. From the shift handover meeting observed, this was led by the night carer rather than the manager. Tasks such as allocation of radio holders, reviews of incidents and risks from the last 12 to 24 hours were not completed. There were new staff including agency and bank staff working who were not familiar with people's needs and risks. Due to care plans and risk assessments being out of date and not regularly reviewed following incidents, this increased the risk of key information not being shared.

The service did not actively collaborate with other services within the organisation or wider community to keep up to date with current clinical practice and access to resources and advice to assist with development of service policies and procedures.

Staff told us they worked closely as a team to offer consistent standards of care and treatment. Staff morale was variable and affected by low staffing levels, incidents during shifts and a lack of regular breaks. Staff gave mixed feedback regarding their relationship with the management team, but acknowledged the manager and deputy had an open-door policy and offered hands on support during each shift. Staff told us they felt their workload was not always distributed evenly, with staff 'doubling up' where people needed one to one support (or higher) at times with insufficient staffing levels in place.

Commissioners assessed and funded support levels for each person during the day and overnight. The episodes of low staffing resulted in people not consistently receiving the level of care meant to be in place. This was impacting on people's access to community activities, and safe working arrangements for staff.

Prior to the inspection, CQC received concerns through the whistleblowing process. When we attempted to discuss this matter, the management team became defensive, and accusatory of who the anonymous

whistleblower must be and the reasons why they would be motivated to contact CQC. This did not demonstrate an open and transparent culture, with the management team lacking insight into potential motivating factors for whistleblowing.

Staff demonstrated awareness of the service's whistleblowing process to enable them to report concerns or areas of unsafe practice. Not all staff told us they felt confident to raise any concerns without fear of reprisals. There were no whistleblowing concerns under investigation at the time of the inspection.

With no up to date annual appraisals in place, and a lack of clinical supervision structure, we could not source assurance that the service robustly identified or managed staff performance issues. However, the director of community services told us one member of staff was suspended at the time of the inspection, pending completion of an internal investigation in relation to clinical competence.

The service did not have good oversight of people's care plans and risk assessments, or mitigation of risks through review processes and sharing of lessons learnt following incidents.

The service identified difficult working relationships with health and social care services, but a good relationship with the local GP surgery.

Outcomes of internal investigations and incidents examined, along with feedback from relatives did not demonstrate good understanding of staff responsibilities in relation to the duty of candour, in the management of complaints, and acknowledgement of where things needed improvement.

The service had a site improvement plan, to improve the condition of the care environment, however, not all risks and areas of improvement identified during the inspection were included in the plan. The management team were in the process of collecting quotes for completion of the works, therefore resolution remained outstanding.

The management team showed us examples of induction paperwork and processes for new staff members. However, this process was not followed when a new member of staff started working on the first day of the inspection. The CQC inspection was cited as the reason why procedures had not been followed.

The service had difficulties with staff retention. Existing staff identified that the role was very demanding, with episodes of staff injury. The director of community services had plans in place to source staff from alternative sites within the wider organisation. The management team needed to recognise the impact that low staffing and lack of breaks within shifts had on staff morale and retention. This also linked to management oversight of staff training completion to ensure staff had the skills required to meet the demands of their roles.

The above information meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified examples of incidents that were not submitted as notifications to CQC. This was explored during the inspection, and the manager had identified an issue with the system for submitting notifications. Having identified the issues, no action had been taken to address this, therefore resulting in notifications not being submitted to CQC in line with the service's legal responsibilities. The management team kept an incident log, we suggested that they added the CQC notification reference number to improve their audit trail.

The above information meant the provider was in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The care provider was not submitting notifications to CQC relating to reportable incidents and safeguarding concerns. Registration Regulation 18 (1) (2) (a) (e) (g) (ii)

The enforcement action we took:

Concerns were imposed on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not working within the principles of the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards. Regulation 11 (1) (2) (3) (4) (5)

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not assessing or managing risks to keep people safe. The care provider did not always manage medicines safely. The care provider did not ensure the care environment was kept clean and prevented spread of infection. Regulation 12 (1) (2) (a) (b) (d) (e) (f) (g) (h)

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The care provider did not have environmental safety checks in place. The provider did not keep people's accommodation in a safe condition. Regulation 15 (1) (a) (e) (2)

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance procedures in place. The care provider did not source views and feedback from people living at the service or their relatives. The care provider did not complete audits and quality checks. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider did not ensure staff received supervision, performance appraisals, training and competency checks to meet the requirements of their job roles. The care provider had not ensured there were sufficient staffing levels on each shift to meet people's care and support needs. Regulation 18 (1) (2) (a) (b)

The enforcement action we took:

Conditions were imposed on the provider's registration.