Care Worldwide (Carlton) Limited

Newbrook

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place 29 August 2017 and was announced. At the last inspection in January 2015 we found the provider was meeting the regulations we looked at; the service was rated as good.

Newbrook provides care for up to three people who have learning disabilities. At the time of this inspection three people were using 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.

The service was not safe because there were not enough staff to meet people's needs and preferences. There was often tension between two people who used the service. A member of staff explained at meal times people were positioned so they did not sit next to each other and did not make eye contact. This meant a member of staff had to sit in between. The service only had two communal areas, which were next to each other. One person spent most of the time in their room. The provider had robust recruitment and selection procedures in place so appropriate checks were carried out before staff started working at the service. Medicines were stored appropriately and medication administration records were well completed, however, care around medicines was not planned to ensure people's needs and preferences were met. Certificates and records confirmed checks had been carried out to make sure the premises were safe.

Staff received training and supervision to help them understand their role and responsibilities. However, they did not feel supported because there was a lack of management involvement. Staff understood people who lacked capacity to make decisions were protected by the Mental Capacity Act 2005. More effective support plans for decision making and considering capacity were being introduced to ensure people's rights were protected. People said they enjoyed the food and had plenty to eat. Pictorial menu cards with instructions for cooking were available and had been used, although not consistently. Menus were not used for planning meals and food records were not always completed. People's care records showed they had accessed a range of health professionals.

People told us staff were kind and it was evident from observations staff knew people well. However, we saw staff sometimes made decisions based on their view rather than providing support that reflected the person's preferences and individual needs. We saw some good care practice where staff engaged with people and encouraged them to make decisions but we also saw practice where staff did not promote people's rights and choice. People's rooms were personalised but the general décor in the home needed attention.

People's needs were not always assessed and support plans did not reflect how they would like to receive their care and support. We were shown a new style support plan for one person's morning routine; this had clear information which guided staff around how care should be delivered. The registered manager said these were going to be rolled out for everyone. People's engagement in activities varied and was often

determined by staff rather than people's preferences.

There was a lack of provider and management oversight, which meant staff worked with very little direction. The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not implemented. A system was in place for managing complaints.

After the inspection the registered manager wrote to us and told us what action they had taken in response to our findings.

"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.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. These related to safe care and treatment, staffing, person centred care and governance arrangements. You can see the action we have told the provider to take at the end 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.

There were not enough staff to keep people safe or meet their needs.

The management team had failed to appropriately assess risk and address issues around compatibility of people who used the service.

People felt safe and staff understood safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained and supervised but did not feel supported in their role.

More effective support plans for decision making and considering capacity were being introduced to ensure people's rights were protected.

People said they enjoyed the food and had plenty to eat, however we found the meals were not varied.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were kind although we saw staff sometimes made decisions based on their view rather than providing support that reflected the person's preferences and individual needs.

Staff knew the people they were supporting well.

People's rooms were personalised.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's support plans did not reflect how they would like to receive their care and support. New support plans were being introduced.

Activities were not person centred.

A system was in place to record and respond to complaints.

Is the service well-led?

Inadequate

The service was not well led.

The provider's quality management systems were not effective.

There was a lack of provider and management oversight, which meant staff worked with very little direction.

Staff had opportunities to share their views, however, there was a lack of information to show suggestions and comments made by people who used the service were acted on.

Newbrook

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.

Before the inspection we reviewed all the information we held about the service including statutory notifications, and contacted relevant agencies such as the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider had completed a Provider Information Return (PIR) in January 2017. 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.

An adult social care inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place on 29 August 2017 and was announced. We telephoned the service and gave them notice on Friday 25 August because it is a small service and we needed to make sure someone was at home.

During the inspection we spoke with three people who used the service, two members of staff and the registered manager. The regional manager was also present but they were new to their post and had not previously visited the service. We looked at documents and records that related to people's care and support and the management of the service.

Inadequate

Is the service safe?

Our findings

We found the provider did not have appropriate staffing arrangements in place. At the time of the inspection only two members of staff were providing cover. Both members of staff alternated and covered a 24 hour period. They started their shift at 10am and finished at 10am the following day. During the night they slept at the service between 11pm and 6am. Staff had a fold up bed, which was stored in the conservatory. One member of staff told us they moved the bed and slept in the dining room. Another member of staff told us they pulled two settees together and slept in the conservatory.

Staff we spoke with told us they had concerns around staffing arrangements; they told us there were not enough staff to meet people's needs. They said people received support from the same workers but the staffing arrangements were not sustainable. One member of staff said, "I'm very tired and I dare not ask for any leave."

In addition to assisting people with personal care the member of staff on duty was responsible for planning and facilitating activities, cooking and cleaning. Both staff we spoke with said they had opportunities during the day to spend quality time with people but were busy at times. Two people received funding for some additional one to one staffing during the week, However, when we reviewed the rotas it was not evident this was being provided consistently.

We concluded staffing arrangements were not appropriate to meet people's needs and preferences. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The registered manager acknowledged the staffing arrangements were not appropriate but said this had only happened recently; one member of staff had left suddenly and another member of staff was absent due to ill health. They said they were recruiting staff and had interviews the day after the inspection. We reviewed the staffing rotas which confirmed two staff had covered shifts for the last two weeks; prior to this other staff had also worked at the service.

After the inspection the registered manager wrote to us and said an additional member of staff was providing 'support to people with activities and one to one time', and a member of the management team would divide their time between Newbrook and another service which would then provide support to the team and 'create more opportunities for people to go out'.

We looked at recruitment records for a deputy member of staff who had spent time at the service and had started working for the provider in the last three months. These showed appropriate checks were carried out before employment commenced.

The provider had systems in place to manage people's medicines. Medication administration records (MARs) showed medicines had been administered correctly. We carried out checks of medicines and found the stock was correct. MARs showed staff checked these each time medicines were administered.

Staff responsible for administering medicines had completed medicines training and their competency had been assessed to ensure they practiced safely.

Some medicines had been prescribed 'as required' (PRN). People had PRN protocols to help staff consistently decide when and under what conditions the medicine should be administered. However, people did not have medication support plans to guide staff around the care people required with their medicines. The registered manager explained new support plans were being introduced and these would cover medication. We concluded care around medicines was not planned to ensure people's needs and preferences were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

We looked around the service and saw this was homely. People freely accessed areas of the home, which included their accommodation. Everyone had en-suite facilities. Some areas of the service needed decorating. The registered manager said the provider had plans to improve the environment and work would commence once they had completed the decoration programme at another service. They sent us a plan after the inspection which confirmed the areas for decoration. Certificates and records confirmed checks had been carried out to make sure the premises were safe. Staff we spoke with said they regularly carried out fire evacuations. We saw weekly fire testing was recorded although there was a gap of six weeks in July and August 2017.

People told us they felt safe. One person said, "Yes I feel safe here. If I didn't I would tell [name of registered manager]. Another person said, "Yes". Staff we spoke with confirmed they had received safeguarding training and told us they would report any concerns to the registered manager. Information about safeguarding was displayed in the home, which helps ensure people know how to stay safe and report any concerns.

Staff told us there had been no safeguarding incidents at the service but there was often tension between two people who used the service. A member of staff explained at meal times people were positioned so they did not sit next to each other and did not make eye contact. This meant a member of staff had to sit in between. The service had two communal areas where people could sit, a conservatory and a dining room, but these were next to each other. We saw one person spent most of the time in their room; a member of staff said this was usual. The management team had taken no action prior to the inspection to address these issues. We saw people sometimes went out as a group with one member of staff, however we were told the risk of people going out together with one member of staff had not been assessed. One member of staff said they did not think this was safe.

We discussed the compatibility issues and limited communal space with the registered manager and operations manager who said they would review the service provision. After the inspection the registered manager wrote to us and confirmed the review had commenced.

We looked at people's individual care records and saw risk was not always appropriately assessed and some information was out of date. For example, one person's assessment stated they needed to prepare before anyone new visited the service, which included telling the person several times and giving them lots of notice. A member of staff told us the assessment was no longer relevant because the approach was no longer required. We concluded care was not provided in a safe way because the risks to people were not appropriately assessed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The registered manager explained new assessments and support plans were being rolled out over three of

the provider's services. They said at Newbrook it was only in the very early stages but was a priority.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they had completed training although one member of staff said they had struggled to find time to complete the required training sessions because they did not have access to a computer at work. We reviewed staff training records but these indicated staff had not completed all their refresher training. The registered manager said the training records had not been updated and sent us an up to date training matrix showing staff had completed training which included moving and handling, safeguarding of vulnerable adults, diversity and equality, fire safety, health and safety, infection control and dignity.

Staff said they had received supervision with a member of the management team but did not generally feel well supported in their role. The registered manager wrote to us after the inspection and outlined their plans for ensuring staff who worked at the service would receive more support from the management team.

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 Deprivation of Liberty Safeguards (DoLS).

The provider had notified us that DoLS had been authorised by the supervisory body. Staff we spoke with had a clear understanding of who had an authorised DoLS. They also understood that the MCA protected people who lacked capacity to make decisions. Training records showed staff had received MCA and DoLS training.

One person who often went out independently told us they could make decisions about their care. They said, "I choose when I get up and when I go to bed. Today, I've had a lie-in and got up at 11am. I don't like going to bed early so I stay up and sleep in when I'm not working." We reviewed people's support plans which had some information about decisions people made such as when to go to bed and get up. The registered manager said they were introducing new support plans which would focus much more on decision making and consider people's capacity. Mental capacity assessments had not been carried out even though decisions were being made on people's behalf; the registered manager said these would be introduced.

One person said, "I haven't cooked for ages but I do help with it sometimes. I enjoy the food here. We choose all the meals for the coming week. I'm on a diet so just have less of the meal we have decided for that day." Other people told us they liked the food and had plenty to eat.

A member of staff said, "We don't do a menu plan as such. We go through the menu folder and pictures of food and the service users pick the meals they want for the week. The shopping order then goes in to buy

the necessary ingredients."

One person went through the menu folder with us. They showed us pictorial menu cards with instructions for cooking and the necessary ingredients. Several healthy options were available. The person told us three or four of the menu choices had been cooked and had a lot of the same food often because they "liked it" and another person "really liked beans" and had them on a regular basis.

We found there was poor monitoring of meals served and the choice of meals was limited. A food record was available, however we saw this was not always completed. For example, there were no entries between 10 and 15 August 2017 so we could not establish what people had eaten. We saw that meals were not always varied. Between 15 August and 28 August 2017 we saw people had sandwiches every day for either their lunch or evening meal and had biscuits for supper every day. On 21, 22 and 25 August 2017 the main meal included sausages.

After the inspection the registered manager wrote to us and said, 'Going forward staff will support residents to choose in their own person centred way but there will also be a written menu planner that will be kept and filed. In addition to this daily logs will include what people actually eat and what there was to choose from. The food is ordered and delivered from [name of supermarket] and receipts show that there is a variety of food delivered to the house.'

Two people told us they attended health appointments including visits to the doctor. We saw people's support plans identified how people's health needs were met. One person's stated they attended annual optician appointments, six monthly dentist appointments and six/seven week chiropodist appointments. Staff we spoke with confirmed people attended these appointments.

Requires Improvement

Is the service caring?

Our findings

We asked people if staff were kind. One person said, "Yes." Another person said, "The staff are kind. And yes, they do treat me with respect. They knock before coming in rooms and they help me to be independent by checking what time I'll be home and what time I might be back. They always ask before giving us our tablets and things."

Staff spent time with people and it was clear they knew the people they were supporting well. Staff were able to tell us about people's family, history and likes. One person had photographs and a book which showed what they had done. The member of staff engaged with the person and went through the photographs. They knew family members and the different places the person had visited.

We saw examples of good care practice where staff engaged with people and encouraged them to make decisions. For example, a member of staff chatted to a person about what they wanted to eat and the person chose a sandwich. The person made the sandwich with the assistance of the member of staff. We also saw some friendly banter between staff and people who used the service. One person was laughing and joking with a member of staff about exercising to burn off their meal. It was evident people enjoyed the company of staff and relationships with staff were very important to them.

We saw also saw examples of practice where staff practice was not caring and did not promote people's rights and choice. One person was near the front door when the inspector and expert by experience were holding a discussion nearby. A member of staff told the person they must come away whilst 'these people do their handover'. The inspector said the person was welcome to join them but the member of staff intervened and said, "No, it's the same when we do our handover they have to stay inside so we can sort things out." This meant the member of staff was not respectful that it was the person's home. Another person went to the kitchen and took a bag of chocolate nibbles from the kitchen cupboard. They did this after one member of staff left the service at the end of their shift. The other member of staff explained the person had waited until the other member of staff had left because they would not let them eat a full bag of nibbles. We concluded care was not always person centred because staff made decisions based on their view rather than providing support that reflected the person's preferences and individual needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Two people showed us their room. These were personalised; decoration, fixtures and furnishing reflected people's preferences. One person had a brightly painted room and they had lots of their favourite items on shelving around the room.

Requires Improvement

Is the service responsive?

Our findings

The registered manager explained new support plans were being rolled out over three of the provider's services. They said at Newbrook it was only in the very early stages. We saw one person had a new style support plan which covered their morning routine; this had clear information which guided staff around how care should be delivered. The registered manager said it was a priority to change everyone's support plans to the new format.

We reviewed two people's care and support records and found these did not identify how people's needs should be met. Some information was relevant but other information was out of date and not person centred. We saw in one person's file there was information about times the person liked to go to bed and get up on a morning; their daily records confirmed this was accurate. However, we also saw some information did not reflect the person's needs. For example, the support plan stated they 'suffer with a lot of anxiety around their clothing being washed so clothing should be dried in the tumble drier despite what the weather is like'. We saw the person's washing was being dried on the clothes line outside; a member of staff told us it had been hung out since the previous day. We saw another person's support plan for 'keeping safe' was not person centred because it focused on staff completing documentation to a high standard and receiving appropriate health and safety training.

One person told us they had been out as a group "on a picnic to Castleford" and was going to London to watch a show with the registered manager a few days after the inspection. However, we found people's activities and daily experiences were mainly determined by staff. One member of staff said, "[Name of staff] takes people out; she likes to get people out and about. I like to do more stay in and help people learn."

We saw one person's support plan stated they should have an activity programme. A member of staff showed us a board which could be used to display the person's daily activities but this was not being used on the day of the inspection. The registered manager said person centred activity programmes would be developed with each person when the new support plans were introduced.

We saw the provider had completed an audit in April 2017. They had identified issues with the support planning, activity planning and risk assessment process. However, it was evident action had not been taken in response to the issues raised. We concluded care and support was not always person centred. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

One person told us, "I've never had to make a complaint. I know the way to do it if I did though. I'd tell [name of registered manager]." The registered manager said no complaints had been received in the last 12 months. We saw the complaints procedure was displayed near the entrance to the service. We also saw a suggestion book had been introduced.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager. However, it was evident from the inspection findings there was a lack of management presence and oversight. Two staff told us the registered manager did not visit the service on a regular basis but was contactable by telephone. They said senior managers visited very infrequently. We asked one person how often they saw the registered manager and they replied, "Not often". The registered manager and deputy manager were included on the staffing rotas; these showed in the six weeks before the inspection they had not worked at the service. The regional manager was at the inspection, however they had only recently started working for the provider and it was the first time they had visited the service. At the inspection, the registered manager and regional manager said they would review the management arrangements and gave assurance there would be significantly more management presence. After the inspection they confirmed this in writing.

At an inspection in July 2014 we found the provider was breaching six regulations. At the last inspection in January 2015 we found the provider had addressed the issues and was meeting all regulations; they were awarded an overall rating of good. At this inspection we have rated the service as overall inadequate; two domains are inadequate and three domains are requires improvement. We found the provider was breaching four regulations, which related to safe care and treatment, staffing, person centred care and governance. This demonstrates the provider had not sustained improvements and had failed to operate systems and processes to assess, monitor and improve the quality and safety of the services provided.

We saw a range of audits were carried out but these were not effective because they did not identify key issues, did not have actions plans or there was a failure to implement action points. The provider had completed a quality audit in April in 2017 where they had identified some issues around service provision; the quality audit report had 21 action points which included mental capacity assessments were not being carried out, specific risk assessments were not being reviewed, food records charts were not being maintained, there were no activity schedules and staff training was not up to date. Timescales for completing the actions ranged from immediately to four weeks or on-going. It was evident from the inspection findings the issues identified had not been actioned and the provider had not competed any followed up.

A member of the management team completed several audits on 23 August 2017, which included a health and safety, infection control; catering, home, financial and medication. We saw these were not robust. No issues were identified with the catering arrangements even though issues had been identified at an audit in April 2017 and we identified issues with recording and the variety of meals. A health and safety audit identified some action points such as 'all wardrobes were not secured to the wall with two fixing points' but there was no action plan to show how the areas would be met. A 'monthly home audit' found well managed rotas were not evidenced, resident meetings were not recorded and care plans did not correspond with assessed notes and identified needs; there was no action plan to show how these issues would be addressed.

Staff told us meetings between people who used the service were held and they attended staff meetings. We

reviewed staff meeting minutes which had been held in December 2016, April, June and July 2017. These showed discussions related to quality and safety and included policies and procedures, health and safety, role of keyworker, financial transactions and safeguarding. Staff told us they were unable to locate any 'resident' meeting minutes. This meant people's views about the service and their experience were not captured. We concluded that the provider did not operate effective systems and processes to enable the registered person to assess, monitor and improve the service or assess, monitor and mitigate risk. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014Good governance.

After the inspection the registered manager wrote to us and told us what action they had taken in response to our findings. They said they had a member of the management team in the area from Monday to Friday who divided their time between two services daily and an additional member of staff to work across two services. They said they had recruited eight new staff who would be working across three of the provider's service including Newbrook. They told us support and risk plans were being updated and written in a clearer and more person centred way. People were being supported to have a weekly activity planner that identified the activities they had chosen. A written menu planner was being kept and professionals were meeting to discuss compatibility of people who use the service.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people's needs were assessed, and care and support was appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care was provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staffing arrangements were appropriate to meet people's needs and preferences.

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 17 HSCA RA Regulations 2014 Good governance The provider did not operate effectively systems and processes. The systems and processes did not enable the registered person to assess, monitor and improve the service or assess, monitor and mitigate risk.

The enforcement action we took:

We served a warning notice.