Mappleton House Care Homes Limited

Mappleton House

Inspection report

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Date of inspection visit:
10 May 2016

Date of publication:
03 November 2016

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

We inspected the service on 10 and 12 May 2016. The inspection was unannounced. Mappleton House provides accommodation for up to 11 people with a learning disability. People are accommodated in one of two houses or a bungalow on the same grounds. On the first day of our inspection 11 people were using the service, however two people were supported to move into another service on this day and so on the second day of our inspection nine people were using the service.

The service did not have a registered manager in place at the time of our inspection and has not had one since June 2015. 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.

Although people were supported by staff who knew how to recognise abuse, action was not always taken to protect people from the risk of harm. People were at risk in relation to how they were supported and from risks from the environment. There were insufficient numbers of staff deployed in the service and medicines were not always managed safely.

People were supported by staff who did not have the knowledge and skills to provide safe and appropriate care and support. People who lacked the capacity to make certain decisions were not protected under the Mental Capacity Act 2005 and had unauthorised restrictions placed upon them. People were not supported to maintain their nutrition and hydration.

People lived in a service where staff were not always respectful of their privacy and didn't treat them with dignity. People's emotional needs were not always recognised and responded to and people were not supported to enjoy an active social life.People knew who to raise concerns with but concerns were not always responded to or acted on.

There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

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.

Action was not always taken to protect people from the risk of harm. People were placed at risk in relation to how they were supported and from risks from the environment.

People did not always receive their medicines as prescribed and medicines were not always managed safely.

There were insufficient numbers of staff deployed in the service to provide care and support to people when they needed it.

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who had not received appropriate training and supervision.

People who lacked the capacity to make certain decisions were not always protected under the Mental Capacity Act 2005 and this led to people having restrictions placed upon them.

People were not supported to maintain their nutrition and hydration.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People lived in a service where staff did not always respond to their emotional needs.

People's rights to privacy and to be treated with dignity were not always upheld.

Staff were given information in relation to what was important to people and staff sometimes listened to people's choices and wishes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not involved in planning their care and support and were not supported to have a social life and to follow their interests.

People could not be assured their concerns would be acted on if they made a complaint.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service.

There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

Mappleton 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 the service on 10 and 12 May 2016. The inspection was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service.

During the visit we spoke with one person who used the service. Some people who used the service had limited verbal communication and some were out so we also relied on observations and spoke with the relatives of four people to get their views.

We spoke with seven members of support staff, the manager and the compliance manager. We looked at the care records of six people who used the service, medicines records of eight people, staff training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

Inadequate

Is the service safe?

Our findings

People were not protected from the risk of abuse and avoidable harm. Feedback from relatives of people who used the service was mixed. One relative told us, 'No it's not safe. I don't like leaving [relative] there." Another relative we spoke with told us, "No I don't feel [relative] is safe." However another relative told us, "Yes [relative] is safe, I have never had any concerns."

People were supported by staff who recognised the signs of potential abuse and how to escalate concerns within and outside of the service, but had failed to do so. Information about people being at risk of harm or abuse was not always shared with the local authority when it should be. This meant that action was not taken to ensure people were protected from the risk of harm.

Prior to our inspection we were informed of incidents which should have been shared with the local authority had not been shared by the management team and external professionals had made the referrals. During our inspection we found other examples of information which should have been shared with the local authority but had not been. There had been a serious allegation made about staff in relation to financial and emotional abuse of people who used the service in 2014. There had been an allegation made about a member of staff in 2015 and there had been an incident when a wheelchair had become faulty and this had caused a person to fall. There was also another incident where a person had been found to have significant bruising from an unknown cause and also two incidents of violence between people who used the service. None of these allegations and incidents had been shared with the local authority for consideration under their safeguarding investigation protocol.

Additionally, we found that staff routinely completed charts (known as body maps) to show where people had been found with injuries such as bruising or scratch marks often from an unknown cause. One relative we spoke with told us, "[Relative] sometimes has marks and bruises, it doesn't seem right." The records did not show what action had been taken in response, such as investigation and sharing the information with the local authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we were alerted to concerns about how people's finances were being managed in the service. This was being investigated by the local authority safeguarding team and the investigation was not concluded at the time of our inspection.

People were at risk of harm because staff did not follow or were unaware of the assessed action to keep people safe. For example two people were at risk if they went out into the community and there was information in their care plans guiding staff on how to minimise the risks. However staff were not always following the information in the care plan and staff told us they did not have the time to read care plans. One member of staff told us, "No I have not had a chance to read the care plans yet."

Another person was at high risk of falling and had suffered recent falls. There was a care plan in place detailing this risk and informing staff how to minimise the risk to prevent further falls. The plan detailed the importance of the person wearing appropriate footwear such as flat shoes when outdoors and slippers when indoors. However on the day of our inspection the person was wearing shoes with a heel whilst walking in the service. This increased the risk of them sustaining further falls.

It was also stated in this person's care plan they were at risk of choking due to missing teeth; however there was not guidance in place informing staff how to minimise this risk. We saw this person walking around with a whole biscuit in their mouth and staff did not take any action to minimise the risk of the person choking on this.

One person had a known risk of burning themselves and there had been concerns raised prior to our inspection when the person twice burnt themselves on a naked flame. We were informed by the manager, at that time, that risk management systems had been implemented to reduce the risk of this happening again. However we saw the management of this was not robust as the actions staff should have been taking, such as signing the person's lighter in and out of the service were not being taken. This meant the person was at risk of suffering further burns. We alerted the local authority to this risk following the inspection.

We saw people were at risk of having food poisoning because basic food hygiene practices were not being followed. These included eating out of date food or food which had been opened for longer than was safe. In all three houses we found a high number of items in the fridge which were either out of date or had no date of opening on them so that staff would know if they were still safe to give to people.

People were not safe in their living environment because action was not taken to ensure people were safe from known risks. One person had a condition which placed them at risk due to eating or drinking non edible items. We saw items such as toilet cleaner and bubble bath was stored in an unlocked cupboard which was accessible to the person. Additionally, in the lounge where this person sat, the armchair was threadbare in places and the stuffing was protruding from it. This presented a risk of the person eating it and potentially choking on the stuffing.

We saw that the temperatures of hot water were tested monthly to ensure they did not exceed the recommended safe level of 44 °C. We saw that in a toilet in one of the houses the water in the sink was regularly exceeding 60 °C and on the day we visited we tested the water and it was 67 °C. People who used the service were at risk of scalding themselves and had access to this toilet. We tested a shower in the other house as the water was too hot to hold your hand under and we found it was 52 °C. We also found the water temperature in the laundry was 53 °C. Both of these areas were open and accessible to people who used the service and we saw that two people in this house were at high risk of scalding themselves. Additionally we saw the care plans for these two people instructed staff to test the temperature of the water and record the value each time they bathed them as the risk of scalding was high. We could not locate any such records and a member of staff told us they did not record these checks. A relative of someone who was at risk of scalding told us they their relative had recently been able to access hot water in other peoples room's in the home. This had also put the person at risk of harm.

In another house we found a toilet sink which was accessible to people who lived in that house was regularly being recorded as exceeding 60 °C and on the day we visited we tested the water and it was 67 °C. One person who lived in this house was at very high risk of scalding themselves and had suffered serious scalding from another source in the past. We informed the local authority of the risks to this person following our inspection.

There had been risk assessments undertaken in 2013 and 2014 in relation to the testing of the water systems to protect people from the risk of legionella. There was no record of the annual risk assessment being carried out in 2015 and we found that not all of the required checks were being carried out to ensure people were protected from the risk. The last risk assessment available in the service asked that staff disinfect the shower heads in bathrooms quarterly. We saw this had been done monthly until October 2014 and then had stopped. The required temperature checks had been carried out regularly until October 2014 and then had also stopped. We asked the member of staff who carried out the maintenance checks and they could not give an explanation of why this was.

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

People did not always receive appropriate care and support as there were insufficient staff deployed within the service. Relatives we spoke with had concerns about staffing levels. One relative told us, "No there are not enough staff." Another relative told us, "[Relative] does not go out as much as [relative] should because they don't have the staff." The manager told us that staffing levels were based as eight staff on duty throughout the day and three staff on duty at night. However some staff we spoke with told us there were not always enough staff to provide care and support to people in line with their needs. One member of staff told us there needed to be nine or ten members of staff to provide one-to-one support and enable people to be offered activities. They told us that having only eight staff impacted on the service people received.

Five people who used the service were in receipt of additional funding to enable them to have one-to-one support from staff due to their support needs. We found this one-to-one care was not always being given and there was a lack of understanding from some staff about who was supposed to receive the one-to-one support and what this actually meant. For example we observed one person who according to records was supposed to receive one-to-one support during the day was left alone on occasions. We asked a member of staff if the person was supposed to receive one-to-one support and they told us they were not. Another member of staff was aware of the support needed but stated they sometimes struggled to give this as there were not always enough staff on duty to provide this level of support. A member of staff told us, "Sometimes we have to move staff around if we are short, sometimes we need to get the people [who need one-to-one support] in one building so that we can keep an eye on them."

Prior to our inspection the local authority had raised concerns with the provider about people not receiving the one-to-one support they were supposed to. They particularly raised concerns about one person. We observed this person during the first day we visited and we saw they were left alone on occasions without the one-to-one support. We saw that there were not always enough staff on shift to provide the support required. We looked at rotas which showed that some shifts only had six or seven staff on shift. This was lower than the levels determined by the provider and meant that the one-to-one support could not be given as intended and people may not be provided with safe care and support. Staff told us that this prevented people from being able to be supported to access the community and to have the stimulation and activities they should have.

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

Steps had not been taken to protect people from staff who may not be fit and safe to support them. We looked at the recruitment process used on the most recently recruited member of staff and saw they had not completed their application form in full. They had not recorded their reasons for leaving previous places of employment. Additionally the management team had not requested a reference from the last place the

staff member had worked. We saw in the files of two further staff that references received did not include details of where the reference had been acquired from. This would make it impossible to audit the files and make sure references had been sought from the appropriate organisations.

We saw the manager had requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in making safer recruitment decisions. However the staff files we looked at only stated the reference number of the DBS and the date received; there was no indication of if there were any issues which were recorded which would necessitate a risk assessment to ensure the staff member was fit to work with the people who used the service.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. Although staff had received training in the safe management and administration of medicines, we saw that medicines were not always given appropriately and staff did not always follow safe protocols.

One person went out for lunch on the second day we visited and we saw that staff had failed to take their lunchtime medicines with them. The person was due to take the medicines at 12.30pm but did not return to the service until 2.30pm. We saw that some bottles of medicines had not been dated on opening to ensure staff knew if they were still within their shelf life. There was also inconsistent recorded of medicines which were to be given as and when required. This would make it difficult to audit medicines records.

We saw that where audits of medicines were carried out, an action plan was put in place to address issues. However we found the actions were not always carried out. For example four months prior to our inspection it had been identified in an audit that all staff needed to be competency checked in relation to medicines. However this had only been completed for one member of staff.

We observed that medicine stock level records were not always correct. One person's records did not match with the amount of medicine in the service. We spoke with a member of staff about this who told us that the person took a box of medicine to their day service with them. There was not a system for checking the person's medicines in and out of the service. This meant it was not clear how much medicine was held by the service, which meant it was not possible to accurately audit the person's medicines.

There were personal evacuation plans in place for staff to follow if there was an emergency such as a fire and people needed support to vacate the service. There were also 'emergency grab sheets' in place for staff to use if a person was transferred to another service, such as hospital. These were detailed with what was important to the person and what risks there were in relation to their health and wellbeing.

Inadequate

Is the service effective?

Our findings

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with had a limited understanding of the MCA and their role in relation to this. We saw that where a person's capacity to make a certain decision was in question, steps were not always being taken to ensure they were supported with decision making or have decisions made in their best interest.

Prior to our inspection the local authority had raised concerns about the lack of MCA assessments being used in the service where people lacked the capacity to make certain decisions. In response to this MCA assessments had been added to people's care plans. However these generally lacked any real meaning in that there was no evidence of how people's capacity had been tested, such as using different communication methods to test. Additionally there was a lack of evidence of a meaningful best interest's decision. For example two people had information in their care records stating that staff could give their medicines covertly. (without their knowledge) There was an MCA assessment in place for medicines but there was no details about how the decision had been made in the person's best interests or if they had been consulted. The assessment did not detail the actual decision being made, which was to give their medicines covertly in food if they refused to take it.

One person had restrictions placed upon them in relation to smoking and another had restrictions placed upon them in relation to food. Neither person had a MCA assessment in place to assess if they had the capacity to make decisions about these restrictions. There was a lack of a best interests decision detailing why the restrictions were in place and why it was felt the restrictions needed to be in place.

Least restrictive interventions were not always being considered. A relative of a person who used the service told us how their family member had been denied access to their bathroom in an attempt to prevent them from accessing their toiletries. This meant that the person was unable to access their toilet. The relative explained how they had intervened to suggest that toiletries were stored in a different location so that the person could access their bathroom and this had been acted on after they had suggested it.

Records showed that prior to the local authority raising concerns about the lack of assessments to

determine if people could make specific decisions, people who used the service, who lacked the capacity to make decisions about their finances, were paying for staff to eat out in restaurants when they accompanied people for their meals out. There had not been MCA assessments carried out to ascertain if people had the capacity to consent to this or if it was in the person's best interest to pay for these meals. We saw the practice of staff having meals paid for had stopped since the local authority raised concerns, however it is of concern that the provider had allowed this practice to happen without the required assessments taking place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of oversight of DoLS in the service. Prior to our inspection the local authority had raised concerns with the provider about a lack of applications for people who may be having their liberty restricted without the authority to do so.

Following this the provider made applications for all of the people who used the service. However there was a lack of understanding of who had already been granted a DoLS. The manager told us there was no-one currently on a DoLS, however we saw from the records of one person that they had a DoLS granted earlier in the year but this had expired. The local authority were taking steps to renew the DoLS, however staff and the manager were not aware of the existence of the DoLS for this person. Another person who used the service had been prevented from having access to their relatives and this restriction had been placed without a required authorisation under a DoLS. This meant the person had their liberty and rights restricted without the required authorisation.

Additionally we observed medicines being used inappropriately in response to a person's behaviour. This person was known to become anxious and agitated in certain circumstances, such as new faces being introduced and a change in routine. There was clear guidance in the person's care plan which gave staff a list of strategies to try and de-escalate the person's behaviour. The plan detailed that if all strategies failed the person could be given medicines, as a very last resort. We observed the person displaying anxiety and agitation during our inspection and staff did not try any of the strategies detailed in the care plan and went straight to the last resort of giving the person medicine to try and de-escalate their behaviour.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had not being given the training they needed to support people safely. Relatives of people using the service had mixed views about staff training, one relative told us, "Staff are not trained to support someone like [relative]." Another relative told us, "Yes staff do seem to get the training they need." Staff we spoke with told us they felt they were given appropriate training although they saidthey felt they needed training in relation to protecting themselves and others when people communicated through their behaviour.

However the records of training given to staff did not evidence that staff had been given the required training in some aspects of care delivery. For example we saw that more than half of the staff had not been trained in safe food hygiene and infection control. One member of staff did not have any training records at all. We saw the provider was responding to this and had booked in several training sessions to try and remedy this issue, however it was a concern that staff training had been allowed to lapse.

People were cared for by staff who were not always given feedback from the management team on how well

they were performing and to discuss their development needs. Staff told us they had supervision from the management team. One member of staff we spoke with said, "Supervisions are helpful we get to discuss concerns." However records did not reflect this and we saw that supervisions were haphazard and were not taking place for all staff on a regular basis.

Where people were at risk of weight loss staff were not always following recommendations made by health care professionals. One person's nutrition had been a great concern and the person had attended the hospital. Records showed that staff had been instructed to weigh the person every three days. We looked at weight charts for the person and there were no weights recorded since 26 January 2016. We asked staff why this was and they told us they were unsure where to record weights as the weight records had been taken out of circulation and there was nowhere to record weights in the new care recording system.

Despite the person being significantly at risk nutritionally their nutrition was not being assessed so that staff were aware if the risk was increasing or decreasing. We asked staff if they supported this person to eat and they told us they thought the person's care plan gave instruction to give the person independence when they were eating. However we checked the person's care plan and there was guidance for staff to sit with the person and encourage them to eat their meal. We observed the person on the first day we visited and staff did not sit with them whilst they ate. This meant the person was not given the support they needed with their nutrition.

We looked at the care records for another person and their nutrition was not being assessed and there were no weight records available to show staff were monitoring the person's weight. We saw from a handover record in relation to a third person that their relatives had raised concerns about the person losing weight. The person's relative told us, "[Relative] has lost a lot of weight recently, [relative's] clothes don't fit anymore. I have raised it but I am not sure what they are doing." However this had not been acted on to ascertain if the person had lost weight and if there was a reason for this.

Another relative we spoke with told us that their relative had gained a significant amount of weight over recent years. They said, "[Relative's] diet is not as good as it could be. [Relative] has gained a lot of weight and exercise has not been stepped up, the diet could have been better." They went to explain that this was impacting on care as the person was becoming harder to support due to their weight. This was not identified as an issue in the person's care plan and no action was planned to support the person in this area.

We observed there was a lack of drinks freely available to people who used the service. Where people had restricted mobility drinks were not left within their reach and on one occasion a person tried to reach for a drink but was not able to access one and was not offered a drink for another 50 minutes.

People were not always supported with their day to day healthcare. Prior to our inspection we received information from the local authority about staff lack of response in relation to seeking health care advice and support for people. One relative we spoke with told us how they had been advised that despite showing signs of pain and distress their relation would be supported to see a health care professional 'when everybody else does'. They went on to explain that this meant waiting around three months and told us that they intervened to get the person treatment.

A relative told us that their family member who was reliant upon the staff to arrange health appointments on their behalf had missed an appointment to have an injection administered. This was not picked up by the staff team and this lack of medication then had an impact on the person's behaviour. Another relative described how their family member had used their behaviour to communicate that they were in pain. They

told us they felt that instead of supporting their relation to access the appropriate health care professional staff responded by giving the person medicine to control their behaviour. The relative explained how they had to intervene to enable the person to access a health appointment and told us how their relation's behaviour had improved once they had been treated for this condition.

Requires Improvement

Is the service caring?

Our findings

Relatives of people living at Mappleton gave mixed feedback about the support provided by staff. One relative told us, "No they are not caring, they don't treat [relative] right." Another relative we spoke with told us, "I have no concerns about how [relative] is treated by staff." We saw mixed observations of staff interacting with people who used the service. On some occasions we saw staff interacting with people in a kind and caring manner. On other occasions we saw staff sitting in the lounge of one house holding discussions between themselves and not involving the people who used the service.

People were not always communicated with in a way that was accessible to them. We saw one persons care plan which clearly described how to communicate with this person. We observed this person being supported by five different members of staff, none of whom followed the communication guidelines in the care plan.

On the first day we visited, two people who used the service were being moved to a different service. Both people had needs around communication and understanding of what was happening and we observed staff were not sensitive to how this may affect them. We saw one person looked distressed and staff did not attempt throughout the morning to reassure them in meaningful communication to explain what was happening. We observed staff spoke with each other, above the heads of these two people, about the move and how they would miss them.

We found staff were not always mindful of people's privacy. We observed one person being supported to wake up and get out of bed and the staff member assisting left the bedroom door open. They also slightly opened the bedroom curtains, which looked out onto the courtyard used by other people. This person's privacy was also compromised by staff supporting another person to access this person's shower room, due to it being safer for the person to use, whilst the person was still in bed. Staff we spoke with told us they felt this was acceptable as the person was asleep.

We observed staff discussing sensitive and personal information about people who used the service, in front of another person who used the service. We also saw examples where people's dignity was not respected. We heard staff speak with people in an infantile and disrespectful manner such as saying, "Good girl" to a person when they did as staff asked them to do. One member of staff we spoke with was describing someone who lived at the service who used their behaviours to communicate and said, "[Person who used the service] is the worst of them all." Staff were also referring to people in records in the same manner. For example we saw two entries in two people's records and staff had recorded, "[Person] has been good today" and "Has been wetting themselves."

People were not always supported to have the things that were important to them. One relative explained how their family member liked to carry a specific object around with them as it made the person feel safe and secure. They told us that this object had been lost on two occasions which had made the person anxious.

People did not always have their wishes and choices respected. We observed one person who needed support to smoke repeatedly asking for cigarettes. This person's relative told us, "They (staff) give [relation] fags when they want not when [relation] wants." We spoke with a member of staff who told us that this person often communicated through their behaviour and this was increased when the person wants a cigarette. They went on to say, "I just give [person] a cigarette when [person] wants one. Its much easier that way."

People were sometimes supported with their independence and developing daily living skills. For example the care records of one person said that staff should encourage the person to prepare meals. We observed this happening in practice and we also saw the person supported to make drinks for themselves and other people who used the service.

We saw examples where people's choice was respected. For example, We observed a member of staff ask a person, "Is it okay if I sit with you." When the person's body language indicated they did not want the staff member to sit with them, the staff member respected this and did not sit down. We saw people wanting to sit in the garden on the second day of our visit and staff facilitated this and people enjoyed some time out in the sunshine and this had a positive impact on one person in particular who was smiling and engaging with staff.

The manager told us that three people were currently using independent advocates to support them with decision making. This meant that people had access to advocacy services when they needed it. Advocates are trained professionals who support, enable and empower people to speak up.

Requires Improvement

Is the service responsive?

Our findings

There were a lack of meaningful activities provided for people, based on their hobbies and interests. A relative told us, "[Relation] does not get out as much as they should." Another relative told us that their relation was often unoccupied or given activities to do that only held their interest for a few minutes. We saw that care plans detailed people's lives and what they liked to do, however this information was not used to inform what activities were offered to people. We saw there was an activities schedule in place but on the two days we visited the scheduled activities did not happen.

Staff told us that more staff were needed to enable them to support people to carry out activities and trips out into the community. One member of staff we spoke with said, "If we only have eight staff on shift this can make doing activities hard." We saw that there were only a maximum of eight staff on the rota for the majority of shifts. We saw that where staff were spending time with people for the hours funded for one to one support, there was often no meaningful activity offered and staff were frequently recording time spent as, 'in lounge' 'in kitchen'.

We saw from the records of one person that additional funding had been allocated for the person to access the community more frequently. There was a note in the person's care plan which stated: 'Staff must prove you are giving four hours community access every day.' We looked at the records kept for the person being supported to access the community and in one week staff had only recorded one occasion where the person had been supported to access the community.

Prior to our inspection we were contacted by three difference sources raising concerns about the quality of care in the service. One of these sources told us they had raised these concerns with the manager of the service but had not received an appropriate response. A relative we spoke with told us, "We keep talking about things but nothing changes." Another relative described multiple occasions where they had raised concerns abut their family members care with the staff or manager but had not had a response, they told us, "I'm not happy with how things here are dealt with, I am not listened to."

We found the complaints system was not robust and we found that the concerns raised by relatives had not been recorded and there was no evidence to show they had been acted on or resolved. We saw there was only one complaint recorded in the service.

We looked at the complaint which had been raised which contained allegations of a serious nature. There had been an investigation and the findings were that there was no 'concrete evidence' that the allegations could be substantiated. The findings asked that further investigation be undertaken to assess if the allegations were accurate. On the day of our visit the management team were not aware of the allegations and could not produce records to show that the further investigation had been carried out.

We saw from a recent audit completed by the compliance manager that staff had highlighted that when they raised concerns with the management team they didn't feel they were dealt with in a timely manner and they were unaware if any action had been taken at all. A member of staff we spoke with said, "I don't

have confidence in the management, we have had so many different managers here."

New care plans were being implemented in the service and these were detailed and gave clear guidance for staff to follow to meet the needs of people. There were plans detailing what was important to people and how their needs should be met. However we found that staff were not always following people's care plans and when we spoke with staff they told us they did not have time to read them. This placed people at risk of receiving inappropriate or unsafe care. We found in one of the care plans we looked at that inaccurate information had been recorded in relation to the person being at risk of choking. The plan gave detail about how to minimise the risk of the person choking but staff and the manager told us this person was not at risk of choking. This showed care plans were not always reflective of people's needs.

Family members and relatives were invited to contribute to people's care plans. One relative we spoke with told us that they had attended a recent meeting at the service to review their family member's care plan. We saw the new care plans were very detailed in relation to people's likes and dislikes with information about what was important to them and how they communicated.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. Since the last registered manager left the service in June 2015 there had been a lack of consistent management in the service. An acting manager had commenced employment and then left, followed by another acting manager who had also stopped working in the service. A further acting manager had commenced working at the service two weeks prior to our inspection. There had not been a handover of the service and any issues which needed monitoring to ensure consistent care delivery. This had led to the quality of the service deteriorating and people were being placed at risk of receiving inappropriate or unsafe care and support. Relatives and staff we spoke with told us that changes in management and a high turnover in the staff team had had a negative impact on the service.

A lack of appropriate governance and risk management framework had resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. The systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff were ineffective. There was a lack of effective systems in place to monitor how incidents, allegations and complaints were acted on and this had led to people being placed at risk of harm and receiving care and support that was not safe.

One relative we spoke with told us about how things in the services had deteriorated over the past two years. The relative told us, "If you had of asked me two years ago I would have said everything was great, I don't know what has happened, there have been a lot of managers in the past 18 months, its affected the stability of the service."

Prior to our inspection we received information of concern from three separate sources in relation to the quality of the service. We were also contacted by the local authority who told us they had concerns about the management of the service and felt there had been a deterioration in the quality of the service provided to people. They had held and continue to hold multi-agency meetings with a representative of the registered provider to seek assurances of improvement and to hold the registered provider to account. They told us there remained heightened concern as there remained little evidence to show a commitment to make the necessary improvements to the service, despite the support given by local authority and social care professionals.

We saw there had been audits completed in the service but where issues had been identified action had not been taken to improve the quality of the service and this had led to people receiving care which was inconsistent and had not met their needs. The audits had not picked up issues that have been identified in this report or if they had, action was not taken to make the required improvements in a timely way. This showed the systems in place were ineffective in identifying where improvements were needed or in bringing about improvements when issues were identified. Had effective systems been in place these issues which placed people at risk of harm could have been identified and acted on prior to us visiting.

Staff told us the new manager was approachable and they would feel confident raising issues with them,

however they told us that the lack of consistent managers had had an impact on the service. One member of staff told us, "Consistency of management is the biggest challenge at the service." Another member of staff told us, "The lack of consistency in the management team has impacted on the team."

People could not be assured that the monitoring of the service would be effective in ensuring they received safe care. We saw there had been a 'mock inspection' carried out by the compliance manager the month prior to our inspection. This had identified some shortfalls in the quality of the service and there was a list of 'areas for improvement'. However a measurable action plan had not been put in place and we found areas identified as requiring improvement had not been completed.

For example the report highlighted that staff were failing to record daily checks of the fire alarm panel and indicated a designated member of staff should have responsibility for this. We looked at the records kept for the daily checks and saw that since the mock inspection this had not improved and out of 13 days staff had only recorded the checks for three of these.

The mock inspection had identified risks in relation to people such as, one person was not receiving appropriate support to prevent them from suffering falls. However we saw on the first day of our visit that this was still the case and the person was still not receiving appropriate support. The report also highlighted a risk in relation to one person from choking on stuffing protruding from a threadbare armchair but on the day we visited the armchair was still in the lounge. The report detailed that one person's window was damaged and coming away from the wall and there was a risk this person might fall out of the window. We found there had been a repair attempt made on this, however the window still showed signs of damage. This meant that despite there being known risks to people, these were not acted on in a timely manner.

Audits designed to identify issues and bring about improvements in the service were not effective. There had been infection control audits carried out in the service but the audits had not identified issues we found. For example, in one of the houses there was a lack of soap for people to wash their hands in any of the toilets, bathrooms and en-suites. We asked staff where they would wash their hands if they supported people with personal care in their bedrooms and they told us they would use the en-suite sinks. However with a lack of soap, staff would not be able to sanitise their hands effectively and this placed people at risk of the spread of infection.

Additionally a quarterly audit of the environment had been undertaken in January 2016 and it had been noted that cleaning schedules needed to be implemented in relation to communal areas of the service. We saw these had been implemented, however staff were not always recording when communal areas were cleaned. Additionally staff were not always recording when people's bedrooms were cleaned. For example we looked at the records for the cleaning of one person's bedroom and staff had only recorded that checks for cleanliness were carried out on eight out of 31 days. We found some communal areas were unclean and there were unpleasant odours in the lounge in one of the houses. In one bedroom we saw the laminate flooring had developed gaps between the slats and this created a risk in relation to the spread of infection which had not been identified by the audit.

The quarterly audit had identified that the radiator cover in one of the houses was broken and needed repair. We checked the radiator cover when we visited and it was still broken and was not secured to the wall.

There were also audit forms in place designed to check the quality of the care plans but these had not been used. We saw that medicines audits had been carried out in the service however where issues were found action was not always taken in line with recommendations made. We saw there was an audit of medicines

carried out in January 2016 and there had been issues found in relation to staff following safe practice. There was an action list implemented which stated, 'assess all staff'. However when we visited the service only one member of staff had been assessed for competency of their medicines practice.

We saw that as part of trying to improve the way the service was monitored the compliance manager had implemented monthly analysis of accidents and incidents. However the analysis was not effective in ensuring all necessary action had been taken following the incidents. We found there were two incidents in the file which should have been referred to the local authority safeguarding team for further investigation and this had not happened. Additionally we found the analysis did not include records kept in people's care plans which detailed injuries people had sustained from an unknown cause.

Additionally there was a lack of learning from incidents in the service. Staff had recorded the details of accidents and incidents in the service but this was not being followed up by the management team and the area of the form used to record any action needed to prevent similar incidents was left blank on most of the forms we saw. There had been an incident when a wheelchair became faulty whilst being used and a person had fallen as a result. Despite this being included in the audit analysis steps had not been put in place to minimise the risk of this occurring again, such as routine checks on wheelchairs to ensure they were safe to use. This meant the analysis was ineffective and did not lead to changes or improvements in the service.

We found that records kept in the service were disorganised, inaccessible and not completed appropriately. For example we found there were records in one of the houses for staff to complete each day to show they had checked food stock in the fridge to ensure food was within its sell by date. These records were frequently not being completed and they could not be found at all in the second house. We looked in the fridges and in one house we found fresh fish which was five days over its best before date and food which was high risk which had not been dated upon opening so we could not be sure if it was safe for people to eat. In the second fridge we found high risk food which had been opened seven days prior to our inspection and should have been disposed of after two days. A member of staff told us they checked the fridges daily but if this happened they had not recognised when food was out of date and placed people at risk of food poisoning. The systems in place to monitor the quality and safety had not been effective in identifying and improving this.

We found that staff had a lack of knowledge of how to record the weights of some people and this had not been identified by the management team. We saw from the weight charts of one person who had lost a significant amount of weight and was nutritionally at risk that staff were not recording the person's weight accurately and this had resulted in staff thinking the person was gaining weight. Staff thought the person weighed much more than they actually did and were shocked when we told them their actual weight.

Daily handover forms had been implemented so that staff arriving on each shift would have an overview of how people were and if there was any information they should know. However we saw these forms were not always completed for all of the people who used the service with the handovers left blank.

We saw that records containing information about people, such as care plans and health action plans were routinely left in communal areas. In one house the records were kept on a coffee table and in another house they were kept in an unlocked cupboard in the lounge. This meant that confidential and personal information was freely accessible to other people who used the service and to people visiting the service. This was a breach of people's right to confidentiality.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the management team were not always notifying us of events in the service. We saw there had been incidents of a safeguarding nature and we had not been notified of these. We also saw one person had been granted a DoLS and we had not been notified of this.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

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 registered person failed to notify the Commission without delay of incidents in the service.

The enforcement action we took:

We cancelled the registration of the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person was not acting in accordance with the 2005 Mental Capacity Act.

The enforcement action we took:

We cancelled the registration of the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way for service users.

The enforcement action we took:

We cancelled the registration of the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not being protected from abuse and improper treatment in accordance with this regulation.

The enforcement action we took:

We cancelled the registration of the registered provider

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity were ineffective.

The enforcement action we took:

We cancelled the registration of the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff deployed in the service to meet the needs of service users.

The enforcement action we took:

We cancelled the registration of the registered provider