

# Alphonsus Services Limited

## Charles House

### Inspection report

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Date of inspection visit:  
18 January 2018  
24 January 2018  
02 February 2018

Date of publication:  
18 June 2018

### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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

This unannounced inspection took place on 18, 24 January and 02 February 2018. At the last inspection on 01 and 31 August 2017 breaches of legal requirements were found and we used our urgent enforcement powers and restricted admissions into the home. We gave the service a rating of 'inadequate' under the questions of 'is the service safe and well-led'. This meant the overall rating was 'inadequate' and the service was placed into special measures. This was because people had not always received the support they required to maintain their safety and well-being. Risks relating to people's healthcare needs and lifestyle had not all been assessed and the action needed to manage and reduce the risk had not always been identified or planned. The service was rated as requires improvement under the questions of 'is the service effective, caring and responsive'. This was because some of the care observed was focussed on the tasks to be completed and not the person. The care provided did not always protect and promote people's dignity. The activities offered and undertaken were not specifically tailored or planned to meet each person's needs and preferences. There was limited evidence to support that people had been involved in the planning of their care. The home had not been consistently well run because the registered manager or provider had not taken the action required to protect people, to escalate concerns, or to ensure the relevant professionals were involved. This had meant people were not consistently receiving a service that was safe and did not consistently meet their needs or comply with the requirements of the law.

During this, most recent inspection, we found the provider had made the necessary improvements to meet the breaches of Regulations 10, 12 and 13 identified at the last inspection. However, there had not been enough improvements to evidence how people were involved in the planning of their care and the activities offered to people were not always personalised to meet each person's identified needs and preferences. The provider's systems in place to assess and monitor the quality of the service provided to people were not always used effectively and required further improvement.

Full information about CQC's regulatory response to issues and concerns found during inspections are added to this report after any representations and appeals have been concluded.

Charles House is a care home and is registered to accommodate up to 10 people who have a learning disability. At the time of our inspection six people were living at the home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

There was a registered manager in post at the time of the inspection. 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.

Systems and processes in place to monitor the safety and quality of the service included the involvement of some people and relatives. The provider ensured that some information was available in different formats to

meet the needs of people. There was a complaints process in place although there had been no complaints for more than 12 months. People and relatives were complimentary about the management and staff, although some staff felt the management team could be more supportive.

People were supported to maintain a healthy diet and all health needs were met with the support from staff. It was evident that people had developed positive relationships with staff. Staff knew people's likes, dislikes and preferences well. However, improvements were required to ensure that care and activities were more personalised and took into account people's abilities, hobbies and interests.

The home required considerable improvement with a number of repairs required to ensure people lived in a safe and homely environment.

We found that people were protected from the risk of abuse and avoidable harm because safeguarding systems and processes were in place. People were supported by sufficient numbers of staff who had the knowledge they required to care for people safely. However, there was improvement to be made with the continuing review of staff members' suitability to support people.

People were supported by staff members that were caring, kind and respectful. However, we found there were missed opportunities to engage with people.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed and reviewed. This ensured that people received the support they required to remain safe. Some people and their relatives were involved in this process alongside any key professionals, to ensure that any decisions made in respect of their care and support needs, were done so within their best interests and in accordance with the Mental Capacity Act 2005. Where people were assessed to lack the capacity to consent to the support they received, the provider had followed key processes to ensure that care was provided in the least restrictive ways possible. Applications had been made to safeguard people against the unlawful deprivation of their liberty, where necessary. People's privacy, dignity and independence were respected.

People received support from staff to take their prescribed medicines. Systems and processes were in place to ensure medicines were managed safely and only senior members of staff who had undergone specific training and supervision were permitted to administer medicines within the home.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive, comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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?

The service was not consistently safe:

People were supported by sufficient numbers of staff that were recruited safely, to ensure that they were suitable to work with people; although reviews to check ongoing staff suitability required improvement.

People were protected from infection and cross contamination because staff members were provided with sufficient personal protective equipment. However some improvement was required with the general cleanliness of the home.

People felt safe with the staff that provided them with support. Staff recognised signs of abuse. Systems were in place to protect people from the risk of harm and staff knew how to report any suspicions of abuse.

People were safeguarded from the risk of harm because risk assessments were in place to protect them.

People were supported by staff to take their medicines as prescribed.

**Requires Improvement** ●

### Is the service effective?

The service was not consistently effective:

The home environment required considerable improvement with a number of large and small repairs required to ensure people lived in a safe and homely environment.

People received care and support with their consent, where possible and people's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted. However, some staff members' knowledge of what could constitute a restriction of a person's liberty was limited and required improvement.

People received care from staff that had the knowledge they required to do their job. However, some refresher training for staff was overdue.

**Requires Improvement** ●

People's nutritional needs were assessed and they had food that they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

### Is the service caring?

The service was not consistently caring:

People were supported by staff that was caring, kind and respectful. However, we found there were missed opportunities to engage with people.

People's independence was promoted as much as possible and staff supported people to make some decisions about the care they received. Although more could be done to promote further independence for some people.

People were cared for by staff members who protected their privacy and dignity.

**Requires Improvement** ●

### Is the service responsive?

The service was not consistently responsive:

People were not always offered opportunities to engage in activities or hobbies that interested them. Activities provided did not always reflect people's individual needs.

Some people and their relatives were involved in the planning and review of their care.

The provider had a system in place to manage complaints to ensure they were dealt with to the satisfaction of the complainant.

**Requires Improvement** ●

### Is the service well-led?

The service was not consistently well-led:

Although the provider had systems and processes in place to monitor the safety and quality of the service, there was significant improvement required to ensure the service operated effectively.

The provider and registered manager had not always ensured that they had kept up to date with their knowledge and skills to

**Inadequate** ●

ensure that the service was continuously developing in accordance with best practice guidelines, particularly in relation to people with learning disabilities.

People and relatives spoken with were complimentary of the management and staff members. However, some staff did not feel fully supported by the management team.

# Charles 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.

The inspection took place on the 18, 24 January 2018 and was unannounced. We then returned for a third day on 02 February 2018 this visit was announced. The inspection team consisted of two inspectors and an expert by experience on the first day and one inspector on the remaining two days. An expert by experience is someone who has had experience of working with this type of learning disability service.

As part of the inspection process we looked at information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. We also reviewed the Healthwatch website, which provides information on health and social care providers. This helped us to plan the inspection.

We spoke with three people living at the home and one relative to gather their views on the service being delivered. Some of the people living at the home were not able to speak with us due to their health conditions and communication needs. We spent time in communal areas observing how care was delivered and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the nominated individual, a director, registered manager, seven care staff and two health and social care professionals. We used this information to form part of our judgement.

We looked at six people's care records to see how their care and treatment was planned and delivered. Other records looked at included two staff recruitment files to check suitable staff members were recruited.

The provider's training records were looked at to check staff members were appropriately trained and supported to deliver care that met people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.



# Is the service safe?

## Our findings

At our inspection on the 01 and 31 August 2017, we found the provider did not meet the requirements of the law. We found the service was not consistently safe and we rated the provider as 'inadequate' in this question. People were not always safe because incidents of potential risk of harm had not always been identified and reported to appropriate agencies. Risks associated with people's needs had not all been identified and assessed. Risks were not consistently managed to reduce the possibility of harm because staff support was inconsistent. This meant the service was in breach of Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

It had been identified at the last inspection that some behaviours had not been recognised as having the potential to be seen as posing a risk to others living at the home. At this inspection we found there had been some improvement. The frequency of events that had given rise to the concerns identified at the last inspection in August had decreased. This was because measures had been introduced in order to reduce the risk of inappropriate behaviours and people's individual needs had been reassessed. We saw from one care file we looked at a positive behaviour support plan had been introduced, which was a way of helping staff to better meet the person's needs. We also saw there had been additional input from health and social care professionals who told us they were satisfied with the measures introduced by the provider for people. One professional explained how they thought the delivery of the service for one person had improved. The registered manager explained to us what other additional support had been introduced to support people that demonstrated behaviours that could be seen as inappropriate or challenging to others.

At the last inspection risks associated with people's needs had not all been identified and assessed. The way staff had managed risks was inconsistent. At this inspection, there had been some improvement. We found there were people living at the home that displayed behaviours as a means to communicate their feelings or as a way of requesting support. Staff we spoke with described what support people required when their behaviour became unsettled. For example, one person was protective about their personal space and would express this through moving their arms and making certain sounds. At the time of our first visit, records we reviewed showed when the behaviour occurred it had not always been accurately recorded. It was not possible to track which other people had been involved or affected by the behaviour. When we returned on the second day of the inspection, improvements had been made.

People we spoke with told us they felt safe. A relative we spoke with told us, "[Person's name] always has someone with them when they go out, they are never left on their own so from that perspective, I believe [person's name] to be kept safe." Staff we spoke with said they felt the service kept people safe. One staff member told us, "We do our best to keep people safe, we want people to be happy here. If anyone shows signs of being distressed or unhappy we will find out why and try to put it right. Since your last inspection, things have got a lot better; we have put things in place to help keep people safe." Another staff member explained, "Not everyone can tell us if something is wrong but we know people here and we know if there is something not right, we can tell by their body language, their gestures and facial expressions." All the staff members spoken with were aware of the events that had been identified at the last inspection and confirmed the situation had improved because additional support had been implemented to mitigate any

risk and keep people safe. Although the provider had met the breaches in Regulations 12 and 13 there was still some room for improvement around the consistency of recording such events.

We found on the days we visited the service, there were sufficient staff numbers on duty. Although one person told us, "They [the provider] could do with some more staff." We asked the person what would happen if there were more staff and they replied, "Could talk to me." Staff we spoke with all felt the service could benefit from one additional staff member as this would give them time to sit and engage with people in a more personalised approach. A relative explained how they thought an additional staff member would support their family member. This was because more time could be spent with the person engaged in meaningful conversations, something that the relative felt their family member would benefit from. Staff explained a reduction in people living at the home, had resulted in one less staff member. We were told that the staffing levels would include the registered manager (part of the day as they also managed another service), a senior and two care workers. The provider did not use agency staff and planned and unplanned absences were covered by existing staff members. On day one of our visit, bank staff were working and we noted this staff member did not know people well and no-one had briefed them about people's individual needs, preferences, or behaviours. We noted there was no attempt to direct the bank staff member to look at daily records or to verbally explain at the staff handover meeting. We discussed our observations of the handover with the registered manager on our second visit. They assured us this was not normal practice and they would raise the matter with the staff members concerned.

Staff members working at the service were established with no-one new having been recently recruited. We looked at two recruitment records and found the provider had adequate recruitment practices in place to ensure staff members employed were safe to support people. This included completion of pre-employment checks, including a Disclosure and Barring check (DBS) before staff started to work for the provider. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people. However, it is good practice for employers to continue to check the suitability of staff and review their DBS approximately every three years. We noted on the two files we checked there had been no review of their DBS since the initial check had been completed over three years ago. The provider's own recruitment policy made reference to check staff members' ongoing suitability annually. Staff we spoke with confirmed they had not been asked to sign an annual declaration confirming their on-going suitability. We discussed this issue with the registered manager who said they would start to review staff files.

People received their prescribed medicines safely. We observed staff administer medicines to people on the first day of our visit. We noted one person was given their medicine with their food, interrupting their lunch, but on checking their records we could not see a medical reason for this to happen. We discussed with the registered manager why medicines were being given with food when it was not necessary. The registered manager told us they would review this. An audit of medicines showed the records to be accurate. However it was noted a large quantity of one medicine was in stock for one person. We asked why this had been accumulated when the person did not require this medicine on a regular basis. We were told the medicine was recorded on the repeat prescription and was dispensed. The staff member responsible for administering the medicines on the day of our visit explained they would return the unwanted medicines and ensure the prescription was up to date. The last inspection had identified that the system to ensure medicines that were no longer required, needed to improve to ensure these were safely removed from the home and destroyed. On the second day of our visit, a new process to monitor and record the return of unwanted medicines had been introduced.

We looked at the cleanliness and hygiene of the home. One staff member told us, "This is a clean home; you won't find any nasty smells." We saw the provider did not employ domestic staff at the home and all cleaning tasks were assigned to care staff. This was in addition to their care duties to support and look after

people living at the home. We completed a visual check of the environment. We found that the day to day cleaning of the home was adequate but noted lots of high level dust and thick cobwebs in communal areas and people's bedrooms. We raised this with the nominated individual and director and a staff member removed the cobwebs at the time of our first visit. Gloves were available for staff to use when providing care. We looked at the laundry and found it was organised although the dryer had been out of use waiting for a new part to be delivered. We also observed the kitchen area was clean and suitable to prepare food, although we noted a cupboard containing dangerous substances was unlocked. This was resolved on the second day of our visit. We looked at cleaning audits and cleaning schedules that staff members were allocated to complete in addition to their care and support duties. Most of the staff we spoke with felt there was a need for a domestic staff member and explained that it was not always possible to spend quality time with people living at the home because of their cleaning duties. A staff member suggested "Just getting someone in a few hours a day, it could be another off duty staff member would help, this would enable a more in-depth cleaning of the home and leave the care staff to attend to people." We discussed this with the registered manager who told us it was a decision taken by the provider

We asked staff if the registered manager shared with them the outcome of investigations into events when things had gone wrong. One staff member explained, "Since the last inspection we have put measures in place that have worked and we support people better now." The registered manager also shared with us their learning from the last inspection. We saw a new recording sheet was introduced on day two of our visit to support the registered manager to identify and monitor for trends with appropriate action to be taken.

## Is the service effective?

### Our findings

At the last inspection in August 2017 we rated the provider as 'requires improvement' under the key question of 'Is the service effective?' At this inspection there had been some improvement, however, the service had remained 'requires improvement.'

We found there were some significant issues with the upkeep and maintenance of the home particularly in the conservatory that was frequently used by people living in the home. The roof contained seven glass panels that were cracked, evidence of damp with a wall covering buckling. Lots of high level dirt and cobwebs and cracked floor tiles. In the dining area around the main bay window was evidence of leaks and on the second day of our visit, a bowl was used to catch the falling water as rain penetrated the window frame and entered the room. There were stained carpets on the first floor and in three bedrooms, the furniture was damaged and a bedroom window would not close properly. There was a large area of damp on the landing underneath the window. On the first day of our visit, our observations were shared with the nominated individual and a director who was shown the areas we had identified. When we returned on the second day a maintenance team was on site and had started to make some of the repairs. The conservatory, at the time of writing this report, was out of use until repairs had been completed. It is acknowledged that the provider started to address the repairs identified at the time of our visits. We have shared our concerns with the local authority. However, it was evident the home had been in this state of disrepair for a considerable length of time and it was only when the inspection team brought the repairs to the attention of the provider that issues were being addressed. The home environment and building was not properly maintained and this was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Premises and equipment.

Staff we spoke with all told us they had received training from the provider. One staff member told us, "The training is good." However, not all of the staff spoken with could say when their last training, for example, on safeguarding had taken place. We asked the provider to send us a copy of their training schedule listing what training staff had completed and when it was due for renewal. We found safeguarding training for 11 staff, as listed on the schedule, had not taken place since March 2014 (due to be renewed in March 2017). One staff member showed no refresher training in safeguarding since June 2007 (due to be renewed in June 2009). Even though staff had not received refresher training relating to identifying abuse; those spoken with had demonstrated in their answers an understanding of what could represent a safeguarding referral and the appropriate action to take. We noted there was no specific training around behaviour management supporting people with learning disabilities and/or a sensory impairment. It was also noted that four staff had not had their competencies assessed in the administration of medicines since August 2016. However there were no issues with medicine administration found at this inspection. It is good practice to ensure training in safeguarding and medicine management is refreshed annually as this will ensure working practices are up to date and in line with current legislation.

It is the responsibility of the provider to ensure that all staff members receive appropriate training to enable them to carry out their duties effectively. The service is specifically for people with learning disabilities and/or sensory impairment. It was apparent from our observations of the home environment, lack of

stimulation for people with more complex or sensory needs and knowledge on where to go for specialist guidance, there was a training need that could be addressed with specialised training or guidance.

The registered manager explained to us that there had been no staff recruited recently that required induction or to undertake the Care Certificate. The Care Certificate is an identified set of induction standards to equip staff with the knowledge and skills they need to provide safe and effective care to people. We were assured that an induction would be provided to new staff as and when required.

Care staff spoken with told us they had regular supervisions. We saw that senior staff members had group supervision. We asked the registered manager was there a reason why senior staff members did not receive an individual supervision. We were told this was used across the industry and had been agreed at provider level. However, the registered manager said they could reconsider with a view to possibly introducing individual supervisions. Supervision is important because it helps to ensure all staff receive guidance and support where required to effectively carry out their duties and understand their role and responsibilities.

Staff spoken with explained how people's needs were assessed. A relative told us, "I am very involved with [person's name] care and the home are very good at involving me in any reviews or assessments of [person's name] care." We reviewed three care files and saw evidence to support that elements were individualised for the person. For example, one file contained specific information on how to discourage and deflect certain behaviours. Staff we spoke with confirmed they had read the updated assessments and were able to tell us how they supported the person with their behaviours. It had been identified at the last inspection that one person had an ongoing healthcare need and there was no information within the care file about how to support the person in relation to their condition. At this inspection we found there was evidence contained within the person's care file that gave information to staff to help support the person. We saw that people had been supported with their health care and support needs and records we looked at demonstrated that people had access to local health care services. For example, the GP, dentist, the optician, podiatrist and community nurses. Staff spoken with explained how they supported people with the healthcare needs. One staff member said, "Most of the staff have worked here for many years and the people living here have been here for years; we know them very well and can pick up on changes in their health." For example, one staff member told us they had noticed one person had become distant and quiet which was 'out of character' and had arranged for an appointment with the GP.

People living at the home received routine drinks and snacks. We asked staff how they offered people meal time choices, particularly for those with limited verbal communication. Staff spoken with explained they planned the menu, taking into account what they knew about people's preferences. One staff member said, "[Person's name] will just push it (food) away if they don't want it and we will get them something else. To be honest, because we know people so well, we know what food they like and dislike." We were told that people were offered choices around food and drinks they liked. However, we saw one person ask for a snack and a staff member bought them a bag of crisps but the person was not offered a choice of flavours to select from. We heard staff say at lunchtime that the choice of yoghurt would be 'lemon, lemon or lemon'. One person told us, "You get what there is, no choice." We saw that meals had been specifically catered to meet people's individual needs. For example, two people had their meals cut into small, manageable pieces. The evening meal time experience saw people sitting together at the dining table and they appeared to enjoy their food which looked and smelt appetising. We reviewed the menu available for people and noted main meals were culturally appropriate and prepared by staff on site at the home.

We reviewed people's weight records and noted they were stable. Where appropriate, we saw referrals had been made to appropriate professionals. For example, one person had lost weight and had been prescribed a fortified drink and diet. A fortified diet is high in calories to help a person increase their weight. At the last

inspection it was noted no care plan identified what a healthy weight would be for people. At this inspection, we saw care plans contained information relating to low or high Body Mass Index (BMI)'s and weight. However, it remained undetermined what people's healthy weights were because their height had not been verified. Without this information, the charts in people's care plans were ineffective at determining what their healthy weight should be. We discussed this with the registered manager and they said they would try to obtain people's heights from past admission and health care records if they were unable to measure people's heights.

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. During our visits to the home, we heard and saw staff offering people some choices about their food, activities and drinks. Staff did patiently explain things to people to help them make some choices. On other occasions we saw that staff gave people a drink, or food without any consultation. Where it had been assessed that people did not have the capacity to make some decisions we saw that best interests decisions had been made in accordance with the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some of the staff members we spoke with were unable to explain why DoLS applied to some people or the implications of this on the way they provided care and support to people. One staff member explained "I think DoLS is about looking after people properly," whilst another staff member told us, "We may have to stop people from doing something that could hurt them and we restrict them from doing it because it's in their best interests." Not all staff members were aware when applications had been approved and whether the approvals were subject to any conditions. Therefore, staff could not always be sure they were acting in a way that protected peoples' rights. The registered manager explained that DoLS applications had been submitted for everyone living at the home, and two people had been deemed to have mental capacity to consent to their care and support. However, we noted on one approved application a recommendation had been made by the DoLS assessor that had not been adopted by the service. We discussed this with the registered manager and at the time of our second visit, the recommendation had been implemented. It was clear on speaking with the registered manager and some of the staff that there was a lack of knowledge around the implementation of DoLS and how this could impact on people living at the home. The registered manager told us training had been arranged for a refresher on the MCA and DoLS legislation.



## Is the service caring?

### Our findings

At our inspection on the 01 and 31 August 2017, we rated the provider under the key question 'is the service caring' as requires improvement. We found the provider had not met the requirements of the law. While staff members were seen to interact with people in a kind and compassionate way, people did not receive a consistently caring service. This meant the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found that the breach had been met, although some improvements were still required.

People we spoke with told us that staff members were kind and caring. One person said, "They [staff] let me sleep." A relative explained they had only good things to say about the staff, "I visit regularly and have no concerns; staff have a genuine interest in people and a very caring attitude." Our observations of the staff showed them to be patient and polite. We saw some positive interactions with people, for example, we saw one staff member supporting a person to stand and walk, talking kindly to them and offering encouragement. However, we also saw some examples of the support being provided focussing on the task rather than the individual. For example, we saw one person, with a visual impairment, had removed their clothes protector, it was replaced several times by a staff member without seeking permission or offering an explanation to the person what they were going to do. We noted there were three staff members in the dining room and two did not chat with the people. One staff member did sit down briefly and asked one person to 'slow down' as they were eating their food too quickly. There was no conversation between staff and people throughout lunchtime. Staff missed opportunities to make the lunch time experience more enjoyable.

Three people we met were unable to tell us about their needs and wishes. We saw that staff understood the way people communicated and patiently supported them. One staff member explained to us because the majority of people had lived at the home for up to 20 years and some of the staff had worked at the service for a long period of time, they knew people 'so well'. We saw staff knew what different words, noises and gestures meant to help people express themselves. For example, we saw one person used hand signs and gestures. Another staff member we spoke with described how one person would use different sounds to communicate how they were feeling.

People we spoke with explained how they would maintain some independence, for example, two people said they chose their own clothes and completed some of their own personal care. We asked staff members how they encouraged people to be as independent as they can. One staff member explained to us there were opportunities for people to help with the food shopping. This was confirmed with one person who told us how they helped staff with the food shopping. We saw that staff did sometimes prompt people to carry out certain tasks for themselves that helped to maintain some level of independence for people. A relative we spoke with told us, "I have always found the staff to be polite and respectful to people here."

Staff we spoke with described how they promoted and maintained people's dignity. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. Our observations overall demonstrated that people were comfortable in the presence of staff, we saw that

staff were friendly and had a clear affection for people. We saw people approach staff for comfort or reassurance when they were unsure or concerned about something. Staff responded by giving people verbal reassurances and hugs. One staff member told us, "I love working here and I love the people."

Staff we spoke with was aware of the individual wishes of people living at the home that related to their culture and faith. Although we were told that no one living at the home practised any particular faith. The meals offered to people were culturally appropriate and staff told us how people enjoyed a takeaway or a 'trip to the pub'. We were told how two people were regularly supported to style their hair in a way that reflected their culture. People could be confident their individual preferences and choices relating to their culture, faith and gender would be respected by staff.



## Is the service responsive?

### Our findings

At our inspection on the 01 and 31 August 2017, we rated the provider under the key question 'is the service responsive' as requires improvement. We found that two people with more complex needs had less access to activities. These two people were at risk of social isolation and at the time, the provider was unable to show that their more complex care needs were being well met. This meant the service was in breach of Regulation 09 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found further concerns which demonstrated the provider had not met this breach.

On the first day of our visit, one person was taken out for the day in the minibus, another person spent the day colouring in their book while three other people were offered little stimulus. We saw that one person was left with a toy car to spin the wheels of and another person had a rattle to shake for most of the day. A staff member explained the rattle had been a gift from a family member and gave the person comfort. We noticed there were 'activity' sheets on the dining room wall however, they were not written in a format accessible for all the people living at the home to refer to and were not personalised as they all reflected the same activities.

Staff spoken with explained that every week everyone would visit the pub for lunch and attend a venue that specialised in 'sensory happiness'. We noticed one person with a sensory impairment was seen to face the dining room wall for much of the day 'feeling' their way across the wall. We checked the person was not distressed in any way and they confirmed to us they were 'okay'. We asked the registered manager what individual interests or hobbies the person enjoyed and how they tried to develop the person's life skills. We were told the person did not require any additional support because 'they had been at the home so long they knew their way around'. We were told the person used to have audio books but the service that provided the books ceased and no replacement had been sourced. We did see that the person enjoyed listening and singing to their music. At the time of our visit, there had been no contact with external agencies to assess the person's suitability for equipment that could possibly support the person. The registered manager said they would make contact following our inspection to ascertain if there were any aids and adaptations available to support the person.

We asked staff about the provision of meaningful activities and hobbies to interest people. They [staff] told us there were a range of activities offered to people, in addition to those previously mentioned, that included an 'exercise lady' and a 'music man' that visited the home. On the second and third days of our visits everyone had gone out in the mini bus. Although there were various activities made available to people these were generally completed as a group as opposed to individualised interests. A relative told us they would like to see their family member receive more input that involved them speaking with other people as this was not always possible with the other people living at the home, which could lead to the person feeling isolated. The relative continued to explain that this was currently being explored by the registered manager.

Two people with more complex and specific needs, although included in the group activities, had much less access to individual activities. Activities that these two people were known to enjoy, for example one person

was very keen on swimming, but this had not been provided for a considerable time. A staff member explained to try and compensate for this the person would regularly have a bubble bath which they enjoyed. Our observations and people's care records showed that although the service offered activities, they did not consistently ensure that each person was provided with support that was tailored to meet their individual needs. There was a risk that some people could be at risk of social isolation and as this had not sufficiently improved from the last inspection the service remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative we spoke with explained how they were involved with the initial assessment of their family member's care and support needs. A staff member told us, "Each person has an allocated key worker. We have monthly meetings with people and we sit at the table in the dining area. Sometimes the person will sit with us other times they will get up and walk away. We do try to involve them by showing them pictures or we try to sign to them." A keyworker is a staff member with specific responsibilities for a particular person. Records we looked at showed that family members were involved and we could see input, where appropriate, had been sought from health care professionals. We also saw meetings had taken place on a regular basis. However, there was little evidence to demonstrate to us how the provider had involved the person in the meeting. The care plans we looked at did contain some personalised information and staff we spoke with were knowledgeable about people's needs and risks associated with their care.

One person we spoke with told us they would speak with a staff member if they were unhappy with something. Another person pointed to a staff member. We looked at the complaints/compliments and noted there had been no complaints since the last inspection. A relative we spoke with explained that they had always found the registered manager to be responsive to any feedback they had raised and was very happy with the service their family member had received. There was an easy read format of the complaints policy. However as, at least three of the people living at the home would be unable to request this, the other way we saw people's feedback was sought was through the keyworker monthly meetings and 'resident meetings'

We found that people were supported to build and maintain positive relationships with people that were important to them. One relative we spoke with told us that they were always made to feel welcome by staff and was regularly updated on their family member's wellbeing.

At the time of our inspection, the provider was in the process of reviewing people's end of life documents. People and their relatives were being supported to make decisions related to their preferences and choices about their end of life care. One relative told us they had arranged to meet with their family member and the provider to discuss arrangements to ensure the choices, decisions and preferences of the person were in place.

## Is the service well-led?

### Our findings

At our inspection on the 01 and 31 August 2017 we found that the quality and governance of the service had not identified where improvements were needed and had rated this key question of 'is the service well-led' as inadequate. We found that people were not always safe, their care needs were not always met and the provider had not met the requirements of the law. This was because the provider's quality assurance systems were not consistently effective and risks to people were not sufficiently managed to reduce the possibility of harm. This meant the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we saw that whilst there were systems in place to monitor the quality of the service and to get the views of people using the service, these had not always identified some of the shortfalls we found during our inspection. For example, we found that medicine audits had not been overseen by management staff which meant that trends and themes relating to staff practices had not always been noted or addressed. Examples of this included excessive amounts of unwanted medicine, out of date eye drops that should have been disposed of, no dates recorded on opened creams. Existing staff records were not checked in line with the provider's own recruitment policy to ensure staff remained suitable to work with people. Audits had failed to effectively identify when staff training required reviewing to ensure staff were kept up to date with new guidance and practice. For example, five staff had not received training in 'autism' since 13 May 2014 and one staff member since 13 May 2012. Fire training for five staff should have been reviewed 04 June 2015 and training in infection control had not been refreshed since 04 and 05 June 2015.

The provider's systems to audit and maintain the upkeep of the interior and exterior of the building also required improvement. For example, the front bay window to the dining room was in serious state of disrepair with visible damage to the external supporting lintel and surrounding brickwork. The conservatory was in a state of disrepair and although it is acknowledged this room was out of use, as a result of expressing our concerns, until repairs are completed; we had been told by staff they had raised the need for repairs with the provider over a number of years. The audits had not identified the urgent need for repairs.

Other quality monitoring practices also required further improvement. For example, at our last inspection we identified recordings of incidents had not been analysed to determine if there was a particular pattern or trend which could be used to plan and reduce future risk. At this inspection, the provider's systems to monitor accidents and incidents for themes and trends in order to mitigate the risk of any reoccurrence still required further improvement. The registered manager had taken some steps, but the recording tool used was a 'tick box' format and did not analysis or identify any trends. We discussed the importance of analysing this information with the registered manager. At the time of our second visit, the registered manager had introduced an amended audit.

Although the provider had systems in place to monitor the quality and safety of the service, they had not always been used effectively to implement or sustain improvements where shortfalls had been identified. As there had not been sufficient improvements made from the last inspection, this was a continued breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

There was a registered manager in post at the time of our inspection. 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 registered manager maintained the home, however, we found that the growth and continuous development of the service was restricted by the provider's and the registered manager's limited knowledge and innovation for evidence based practice. This was particularly around personalised care and learning disability, notwithstanding that the provider promoted themselves as a specialist in the provision of care to a learning disability service. This was evident in the absence of a 'user' friendly environment. For example, although the conservatory was currently out of use, there was a missed opportunity to develop that area of the home into a more suitable sensory environment to potentially enhance the lives for the people living in the home. The home lacked specialised activities and interventions, which could be adopted and developed through self-directed learning, research and engagement with specialist services.

There was a clear leadership structure within the service and people and relatives we spoke with were positive about the management of the home. One person said, "I know [registered manager's name]." A relative told us, "I have always found [registered manager's name] to be professional, helpful and responsive when I have raised things with them." We found that the registered manager was visible throughout the home and knew people who lived at the home, as well as their family members. They spoke about people with kindness and familiarity. Staff we spoke with told us, "[Registered manager's name] is very hands on, they are in most days helping to do the breakfast." Some staff members felt the management team could be a bit stronger when things needed to be done and there could be some improvement with the support they received from the management team. However, all the staff we spoke with enjoyed working at the home and this was supported by the number of years some staff had been there. Comments included, "I can't imagine being anywhere else," "I love it here, the people are great, we are like a big family."

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and there was a whistle-blowing policy in place. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concern properly.

We saw the provider had tried to obtain feedback from people who lived at the home and their relatives about the quality of the service. Each month there were resident meetings and it was indicated in the minutes which method of communication was used to support people to make some choices.

It is a legal requirement that the overall rating from our last inspection is displayed within the home. We found the provider had displayed their rating.

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us their understanding of this regulation and we saw some evidence of how they reflected this within their practice. A relative we spoke with explained how accommodating they had found the registered manager to be and how they were always prompt to contact them if there were any concerns or issues. They told us, "I have always found [registered manager's name] to be honest."

We found the provider had been compliant with their registration regulations by way of submitting statutory notifications. However, we found there was one incident that had occurred that we had not been notified about. We discussed, post inspection, with the registered manager and reminded them of their responsibilities to report all notifiable incidents to CQC as soon as possible. Providers are required by law to inform us of certain events that happen within the home (such as serious injuries, safeguarding concerns or deaths) by way of submitting a form called a statutory notification. We found that the statutory notifications we had received from the provider were adequately detailed enabling us to have an understanding of events. Whenever we requested additional information concerning an event that they had notified us of, this had been provided to us.

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 | <p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>Our observations and people's care records showed that although the service offered activities, they did not consistently ensure that each person was provided with support that was tailored to meet their individual needs. There was a risk that some people could be at risk of social isolation and as this had not sufficiently improved from the last inspection the service remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> |

### The enforcement action we took:

A requirement notice was issued

| Regulated activity   | Regulation   |
|--|--|
| Accommodation for persons who require nursing or personal care | <p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>It was evident the home had been in this state of disrepair for a considerable length of time and it was only when the inspection team brought the repairs to the attention of the provider that issues were being addressed. The home environment and building was not properly maintained and this was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.</p> |

### The enforcement action we took:

A requirement notice was issued

| Regulated activity   | Regulation   |
|--|--|
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Although the provider had systems in place to monitor the quality and safety of the service, they</p> |

had not always been used effectively to implement or sustain improvements where shortfalls had been identified. As there had not been sufficient improvements made from the last inspection, this was a continued breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

**The enforcement action we took:**

A requirement notice was issued