Eden Health Care Services (UK) Limited

Acorn Lodge Care Home

Inspection report

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26 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 20 & 26 June 2017 and was unannounced.

Acorn Lodge is a residential care providing care and support for up to 15 adults who have a learning disability and support for people living with dementia. At the time of our inspection there were 11 people using the service.

The service has a registered manager who is also the provider. 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.

This inspection was prompted in part following information of concern received from the local authority and their safeguarding team telling us people were at risk of not having their needs responded to in a safe and effective way. At this inspection we identified a number of serious concerns.

We returned to the service to complete the inspection on 26 June 2017 and found that many of the urgent concerns identified on 20 June remained and we continued to identify concerns which escalated the risk to people using your service. Urgent action was required to make improvements as we found major concerns in relation to the lack of competent, skilled and knowledge staff available to provide safe care and treatment to people at all times of the day and night. There was a failure to ensure that service users were protected from the risks associated with improper operation of the premises including inadequate fire safety systems and processes. This meant that the safety and welfare of people using the service was at risk and the provider was failing to provide a safe service. In response to our findings we asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards.

Immediately following our inspection we notified relevant stakeholders such as the local safeguarding authority and Essex Fire service of our findings.

People did not receive safe and responsive care. People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place and operated effectively. We found there was inadequate numbers of skilled and knowledgeable staff employed with a command of English which would enable them to understand and respond to people's health, welfare and safety needs. These staff were sometimes left in charge at night and we were not assured that they could respond to emergency situations and communicate effectively with people to enable them to understand, be understood and be able to respond to appropriately to people's care and treatment needs.

People were not always supported by staff that had the necessary skills and knowledge to meet their needs.

Staff did not always receive appropriate and effective training and supervision support which meant staff had not received adequate training to deliver effective care. Not all staff were familiar with safeguarding procedures and had not received adequate training on recognising and responding to acts of abuse and keeping people safe.

There were systems in place to manage people's medicines in a safe way. However, we recommend that the provider reviews its procedures in relation to the safe storage of medicines to ensure people's medicines are stored at a safe temperature and ensure that they are compliant with best-practice guidance for storage of medicines in care homes.

Staff had limited resources such as adequate staffing to enable them to fully enhance people's quality of life. Whilst staff were kind and caring in their approach they were often task focused. People did not always have the communication tools they needed to make themselves understood.

The provider did not promote a culture that encouraged openness, transparency and honesty at all levels. There was also a failure of the provider to notify CQC of incidents being investigated by the police as they are required by law to do so.

The provider had a limited governance system in place to monitor the quality and safety of the service. This was inadequate as it did not identify the shortfalls we found and identify the risks to people's safety and welfare. For example, in relation to fire safety, the safe moving and handling of people and the insufficient numbers of skilled and knowledgably staff, available to meet people's needs at all times.

Care and support plans were cumbersome, repetitive with lots of information which was difficult to navigate. Not all care plans were personalised with some records containing generic information which had been copied and pasted which resulted in people being referred to by the wrong name and incorrect gender.

People were not always supported to take part in meaningful activities. Staff did not have up to date, skills and knowledge as to current good practice in meeting the needs of people with a cognitive disability including those living with dementia and those with a learning disability.

People had access to healthcare services but access was not always provided in a timely way which meant people were put at risk of delayed access to treatment. People were weighed monthly and weights recorded. However, it was not always clear what action had been taken to support people who had been identified as losing weight.

We were not assured that the registered manager and staff had up to date, skills and knowledge as to current good practice in meeting the needs of people with a cognitive disability including those living with dementia and those with a learning disability.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

There were insufficient numbers of staff at the service to support people according to their assessed need and support them safely. The provider did not carry out safe recruitment and selection of staff to ensure staff were skilled and knowledgeable and able to communicate and understand people's health, welfare and safety needs.

People did not always have risk assessments based on their individual care and support needs and were not always protected from environmental risks including the risk of being trapped by fire.

Not all staff employed had sufficient command of English to be able to communicate effectively with people who used the service and respond to their care and treatment needs as well as respond in the event of an emergency when left in sole charge of the service during the night time period.

Staff were not all familiar with safeguarding procedures and had not received adequate training on recognising abuse and keeping people safe.

There were systems in place to manage people's medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported by staff that had the necessary skills and knowledge to meet their needs. Staff did not always receive appropriate and effective training and supervision support which meant staff had not received adequate training to deliver effective care.

People were weighed monthly and weights recorded. However, it was not always clear what action had been taken to support people who had been identified as losing weight.

People had access to healthcare support but this was not always delivered in a timely way.

Is the service caring?

Requires Improvement

The service was not always caring.

There were positive comments from people about the staff being kind and caring towards them However, there was an institutional feel to the service as staff were mainly focused on tasks.

Staff had limited resources such as adequate staffing to enable them to fully enhance people's quality of life.

People did not always have access to the communication tools they needed to make themselves understood and enabled to be involved in the planning as to how they lived their daily lives.

Is the service responsive?

Inadequate

The service was not consistently responsive.

Care and support plans were cumbersome, repetitive with lots of information which was difficult to navigate. Not all care plans were personalised with some records containing generic information which had been copied and pasted which resulted in people being referred to by the wrong name and incorrect gender.

People were not always supported to take part in meaningful activities. Staff did not have up to date, skills and knowledge as to current good practice in meeting the needs of people with a cognitive disability including those living with dementia and those with a learning disability.

Daily notes were detailed but were not monitored for patterns or trends.

Is the service well-led?

Inadequate

The service was not well led.

The provider had a limited governance system in place to monitor the quality and safety of the service. This was inadequate as it did not identify the shortfalls we found and identify the risks to people's safety and welfare.

The provider did not promote a culture that encouraged openness, transparency and honesty at all levels. The provider failed to notify CQC of incidents being investigated by the police as they are required by law to do so.	

Acorn Lodge Care Home

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 checked 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.

This inspection was prompted in part following information of concern received from the local authority and their safeguarding team. At this inspection we identified a number of serious concerns. One incident is currently subject to a police investigation. However, the information shared with CQC about the two incidents indicated potential concerns about the management of risk. This inspection examined those risks.

This inspection was carried out by two inspectors and took place on the 20 & 26 June 2017 and was unannounced on both days.

Before the inspection we received information of concern from stakeholders about the quality and safety of the care people received. We also reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the care of people living in the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

During our inspection we spoke with two people who were able to verbally express their views to us. Other people had limited ability to verbally communicate their views of the service to us and therefore, we observed how care and support was provided to some of these people.

We spoke with the registered manager, the deputy manager and five care staff.

We checked staff rotas for the last eight weeks prior to our inspection, agency staff invoices, and the recruitment and training records for the last three staff appointed. We also looked at five people's care records, including records in relation to the management of people's medicines, and the quality and safety monitoring of the service, including risk management.

Inadequate

Is the service safe?

Our findings

Although two people who were able to speak to us told us they felt safe and liked living at Acorn Lodge, we identified major concerns where people's welfare and safety was being compromised and they were being put at risk.

Prior to our inspection we received information of concern in relation to the safeguarding of people from harm and improper treatment. Whilst one incident is closed and found unsubstantiated the other incident continues to be subject to police investigation. Information shared with CQC about the two incidents indicated potential concerns about the management of risk. This inspection examined those risks as well as all other standards required.

We found risks to people's welfare and safety had not always been assessed appropriately and the provider was not doing all that was reasonably practicable to mitigate any such risks. Risk assessments had been completed in areas such as mobility, eating and drinking and medication. However, the assessments often contained generic information which had been copied and pasted, some with the wrong name, gender and were not person centred. Risks in relation to the administration of people's medicines rather than clearly describing actions for staff to take to mitigate risks stated, 'all staff to complete training.'

We found disparities in risk assessments. We found some had not been updated appropriately with actions described to reflect the current needs of people at risk of scalding, acquiring pressure ulcers and whilst out in the community. Where it had been recommended following safeguarding incidents that the provider implement pain assessment tools to enable staff to assess when people with limited verbal communication skills may be in pain and respond appropriately these had not been implemented.

We asked the registered manager if there was anyone at risk of acquiring a pressure ulcer or who currently had a pressure ulcer in situ. They told us there was no one. A review of care records showed us that there was one person who had been identified as having acquired pressure ulcers on both heels and on their left hip, which was described as ongoing. In January 2017 the visiting community nurse had recorded in their notes where they had identified a person having a sacral pressure sore for which they instructed staff to closely monitor. We could not find any records which would indicate that staff had been monitoring this area and neither what grade of sore had been diagnosed or if and when this had healed with no further action required.

We looked at repositioning records for one person who received care in bed and needed to change their position every four hours to alleviate pressure and prevent the risk of them acquiring a pressure ulcer. Staff had recorded regular repositioning as required. Pressure relieving equipment was in place such as air flow mattress. This was set at the correct weight for the person and was regularly monitored. However, we found this person had lost 50% of their body weight in the last 18 months as a result of deteriorating health but no reassessment had taken place to ensure the hoist sling used to mobilise this person was of the correct size and staff continued to use the same sling assessed for the previous body weight. This put this person at potential risk of falling through the incorrect size of sling for their body weight which could result in serious

harm. We discussed this with the manager and requested they take immediate action to rectify this.

On the second day of our inspection six days after the first visit we found that the provider had failed to take action to contact an occupational therapist to provide a specialist assessment of any potential risk to this person of falling from a hoist. We also found that no action had been taken to update their moving and handling plan to guide staff as to the actions they should take to mitigate any potential risks and include a description of the sling to be used.

Since our inspection and instigated by the local authority we have been informed that an occupational therapy assessment has been carried out and the hoist sling in use has been assessed as of a suitable size. However, we remained concerned that prior to this the provider did not demonstrate any awareness of the need to consider that people with significant weight loss are at risk of falls from hoist slings and of the need to check with those qualified to do so to assess whether or not the current sling in use is of a suitable size for their weight. This has the potential to put people at risk of serious harm.

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

The provider had produced some environmental risk assessments where they had identified some risks to people's welfare and safety. However, further work was required to risk assess all areas of the service which posed a risk to people including staff and others. For example, we reviewed the provider's fire risk assessment. This contained inaccurate information with regards to the use of rooms on the top floor where we found two staff were living. We noted that all external fire doors required a key to open them in an emergency. Not all staff had access to keys and should people need to evacuate the building in an emergency there was a lack of guidance as to how this would be managed. We also found a corridor door and a number of bedroom doors wedged open. Internal doors including the door to the kitchen did not have intumescent strips and sealant to prevent smoke from entering rooms.

We found a large gas canister stored inside the building amongst other combustible material at the top of a flight of stairs. We asked the provider to remove this immediately. Gas bottles should be stored away outdoors, away from building entry/exit points. No assessment of risk had been carried as to the storage of gas bottles in use with actions identified to mitigate the risk of harm.

Personal evacuation plans (PEEPS) had been recorded for each person who used the service with actions to take in the event of a fire or other emergency where there was a need to evacuate people from the building. However, these had been filed away in each person's care records and had not been centralised to enable staff easy access in the event of an emergency.

Immediately following our inspection we contacted Essex fire service to inform them of our concerns regarding people's safety at the service. In response they carried out a fire safety audit of the service. In response to a number of shortfalls they identified including those we found they issued the provider with a deficiencies notice, giving them eight weeks to take action to comply with fire safety regulations and mitigate the risk of harm to people who used the service.

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

Within the care service accommodation was provided for overseas workers recruited via an external agency. The registered manager told us that only two staff lived within the service and that these staff worked

predominantly nights but also day shifts and on call duties were available to be called upon during the night in the event of an emergency. However, we found out on the second day of our inspection that there was in fact three staff living in the service and a fourth arrived during our inspection to move into the accommodation provided ready to work. We noted from discussions with staff and a review of the rotas that these staff were sometimes left in charge of the service during the night time period.

We spoke with three of these staff and found that they had very limited understanding of the English language and when asked about the night time needs of people they cared for they were unable to fully understand what was being asked of them. They also when asked about any training they may have received, their knowledge and understanding of how to recognise and report abuse, were unable to understand and respond to what we were asking of them. We were therefore not assured that these staff were able to understand and respond to the health, welfare and safety needs of people who used the service. This arrangement also had the potential to put people at risk of being cared for by staff who did not have the skills and knowledge to meet their needs, to take charge and respond to night time emergencies and mitigate people from the risk of harm.

Rotas were misleading as names stated on the days differed to those on nights when they were one and the same person. Staff regularly worked in excess of 60 to 90 plus hours per week with little time off with some working day shifts when also rostered to work the same night. Care staff were required to clean the service, prepare and cook meals as well as process laundry as there was no other designated staff employed for these purposes. Whilst staff were needed to support people with their personal care we noted food was left on the stove, cooking in the kitchen unattended for significant periods of time which could present a risk to people's safety.

We found rotas did not always reflect the actual members and numbers of staff on duty. For example, where the registered manager was on holiday they had been recorded on the rota as working. Where staff did not turn up for work, were on leave or left the shift early, the rota did not reflect these changes. There were two awake staff rostered on between 20:00 until 08:00 with an on call person who was required to sleep at the service but were not paid unless they were called to attend to people's needs. We found that there was not always someone allocated to be on call.

Where people required and had been funded for one to one care support this was not always provided. We found from a review of rotas and discussions with staff inadequate numbers of staff on duty to ensure people had the required one to one support to meet their needs and keep them safe whilst out in the community. The registered manager told us there was at least five staff available during the day to meet the assessed needs of people. Two people required one to one support at all times. Two other people required support from two staff in meeting their personal care needs. However, we found only three staff on duty on the second day of our inspection. Following a review of the rota we also found only three staff scheduled to work on three days in the same week following of our visit and this was confirmed by staff.

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

People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place and operated effectively. We discussed with the registered manager the process that had been used for the recruitment and selection of staff. They told us there was only one staff vacancy was waiting to be recruited into. We reviewed the recruitment and selection records for the member of staff who we were told would commence work once all disclosure and barring (DBS) checks had been processed and satisfactory references received. However, on our second visit we found that this person had started work

the following day after our first visit without the required safety checks having been completed.

On the second day of our inspection we found a relative of the registered manager, who was not employed by the service transporting two people in their car along with a member of staff. We were not provided with any evidence that safety checks had been carried out and including adequate insurance in place to do so.

Our findings did not assure us that the provider had recruitment and selection systems and processes in place, established and operated effectively to safeguard people and protect them from the risk of harm and from receiving inadequate care, treatment and support.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored in a dedicated locked trolley which was kept in a lockable treatment Cupboard. We carried out a check of stock against medicines administration records (MAR) for four people. Stocks of medicines tallied with the MAR records with no errors identified. There were clear records with regular audit of stocks carried out by night staff. There were no controlled drugs held by the service.

Staff received training in the safe administration of medicines and safe storage and completion of records. Records reviewed showed us that staff competency for administering medicines was assessed on a regular basis.

Unless stated otherwise in product literature and labels, the majority of medicines that do not require refrigeration can be stored under conditions of controlled room temperature without compromise to their stability and recommended shelf life if stored at between 21c and not exceed 25c. We found the room temperature where medicines were stored in the afternoon recorded a temperature of 31c. No temperature had been recorded on the daily temperature record for this day. We questioned the accuracy of the recording of the room temperature's for the previous week as we were experiencing a heat wave with temperatures of 30c plus and temperatures recorded ranged from 21c to 25c. There was no electronic temperature probe which would ensure accuracy of temperatures recorded and there was no cooling equipment within the storage cupboard to ensure people's medicines were maintained at a safe temperature. There is a requirement that Temperature monitoring take place on a daily basis (preferably at the same time each day) and the actual, maximum and minimum temperature should be recorded. Temperature records should identify any temperature deviations and give details of corrective actions taken as a result. For instances where there has been a temperature deviation, best practice would be to take a further reading later the same day, to ensure that it was a transient deviation and show that the temperature was now back within prescribed parameters. We recommend that the provider reviews its procedures in relation to the safe storage of medicines to ensure people's medicines are stored at the safe temperature and ensure that they are compliant with best-practice guidance for care homes.On the second day of our inspection six days after the first visit we found that the provider had failed to take action to contact with an occupational therapist to provide a specialist assessment of any potential risk to this person of falling from a hoist. We also found that no action had been taken to update their moving and handling plan to guide staff as to the actions they should take to mitigate any potential risks and include a description of the sling to be used.

Requires Improvement

Is the service effective?

Our findings

Not all staff were suitably competent, skilled and experienced to meet people's care and treatment needs. Some of the people living in the service had a diagnosis of dementia, a learning disability or had a mental health diagnoses. Some people presented with behaviour that may challenge as a result of their mental health condition. Other peopled had a learning or physical disability.

Prior to our inspection we reviewed the information as stated on the provider's website as to the level of care and support provided. The provider's website contained information which claimed that staff had received training which provided them with the skills and knowledge and ability to meet the needs of people with complex conditions including; schizophrenia, Asperger's, autism, bipolar disorder, sensory impairment, dementia, learning disability including downs syndrome, Prader Willi syndrome, Corneli de Lange syndrome and Magenis syndrome. Following discussions with the registered manager, staff and a review of training records we found that other than some staff having received epilepsy training and some staff training in meeting the needs of people diagnosed with autism and dementia no other training as claimed in relation to these conditions had been provided.

The majority of training staff received was provided on line with some face to face training such as moving and handling which we were informed by the registered manager was provided alongside first aid, emergency treatments both within the one day of training. The registered manager told us moving and handling training included a competency assessment of staff using safe techniques and the use of equipment such as hoists and slide sheets. We saw that for one person with a percutaneous endoscopic gastrostomy (PEG) in situ to enable them to receive nutrition intravenously through the stomach wall, staff had received training in the safe use and maintenance of this system. However, we were not assured that the provider had verified the competency of staff who had been recruited via an agency to live and work in the service as to their understanding of any of the training they had received whether face to face or online given their limited command and understanding of the English language.

People had access to healthcare services but access was not always provided in a timely way which meant people were put at risk of delayed access to treatment. Some people had been supported to access community nurses, chiropody, dental services as well as annual health checks via their GP. Where people required regular depo injections to maintain their mental health these had been recorded in the diary and corresponded with daily records to evidence people had received access to these procedures.

We observed one person being permanently cared for in bed, their breathing was observed to be laboured and wheezy which could indicate a possible chest infection. The manager told us that this person had been regularly monitored by their GP. However, when we reviewed this person's care records there was no evidence of any GP visits to assess this person had taken place since January 2017. We asked the provider to immediately request a GP to visit. On the second day of our inspection we checked to see that action had been taken and were advised the GP had visited and had prescribed antibiotics to treat a chest infection.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

On the first day of our inspection, mid-morning we found liver and bacon and potatoes boiling away on a cooker which was unsupervised by staff for a significant period of time which we pointed out to the registered manager could present a risk to people's safety. There was a bowl of pre-cooked mash which we were told would be used to make a cottage pie with meat which would be taken directly from the freezer. We later found the meat had been added to frozen veg with the mashed potato placed on top and did not look appetising. The menu for the day described seasonal fruits for pudding but these were not available. Food provided was basic, supermarket value products, some processed with little fresh fruit and vegetables provided and only the occasional salad provided.

We found out of date food in the fridge including sausage rolls and pre-packed pastry. Pre-made sandwiches within the fridge had not been dated along with jars of mayonnaise also not dated. The pre-packed pastry was still in the fridge when we carried out the second day of our inspection six days later. This meant we could not be sure that adequate food safety standards had been maintained and people protected from the risk of harm.

Staff told us people chose what they wanted to eat on a daily basis. However we found people had not been involved in the planning of menus or those with limited cognitive the ability and or lacking verbal communication skills provided with pictorial aids to support them in making their wishes and preferences known. There was no guidance as to what if any specialist diets were required.

Care staff prepared and cooked meal. There was no designated kitchen staff for this purpose. We observed the lunch time meal in the dining room. Where people declined their main meal no other alternative was offered only pudding. We observed where people required assistance to eat their meal they had been supported by staff sensitively sat eye to eye undisturbed but with little verbal interaction. We observed people had access to regular drinks and noted jugs of juice available throughout the service.

People were weighed monthly and weights recorded. However, it was not always clear what action had been taken to support people who had been identified as losing weight. For example, one person had recently lost 3.2kg of weight within a two month period but there was no record of any actions taken to support this person who we saw refused their meal at lunch time on the first day and at tea time on the second day.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Two people who were fairly independent told us that they felt safe and that staff were kind to them. One said, "Yes the staff are kind." And another, "I like it here."

We were unable to speak to the majority of people to ascertain their views as to the approach of staff in caring for them due to their limited verbal communication skills. We spent time observing interactions between staff and found staff to be friendly and kind in their approach towards people.

During our inspection we found that staff were working under conditions which made it difficult to promote a caring, person-centred environment. The service had an institutional feel whereby staff although kind in their approach to people were focused on task related activities such as cooking, cleaning and supporting people with eating their meals where this was required and personal care tasks. Staff had limited resources such as adequate staffing to enable them to fully enhance people's quality of life.

There were aspects of dignity and privacy that were maintained with people. When staff went into people's rooms they knocked on the door before entering. When personal care was being provided to people staff ensured doors were closed to maintain people's dignity.

Information was not always provided to people in an accessible way that was meaningful to them and the environment did not support communication. For example, there were no pictures of the activities which would be happening. There was no information displayed about what people could choose to eat that day. There was a board in the lounge that had some pictures of some food displayed, but his did not reflect what was actually on the menu for the days we inspected. Some people sat for long periods of time in the lounge with little activity.

People were not always provided with information they required in a format they would understand and would enhance their involvement in making decisions about their everyday lives. For example, there were no pain assessment tools or the use of DISDAT, a Disability distress assessment tool. This is a tool which records how people communicate if they are unhappy or unwell through their behaviour or facial expressions. This information was not always added to people's care plans or risk assessments, so staff were unaware of it and of the signs to look for when supporting people.

We were not assured that people were always involved in the planning of menus and planning for their social and community activities. Menus and activity plans were not produced in formats such as pictorial formats or other recognised formats such as PECS, a picture exchange system which is a form of alternative communication produced for individuals with autism spectrum disorder. These formats would enable people with limited cognitive ability to understand and exercise choice over what they ate and planning for how they lived their daily lives. We were not assured that the registered manager and staff had up to date, skills and knowledge as to current good practice in meeting the needs of people with a cognitive disability including those living with dementia and those with a learning disability.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Care and support plans were contained in folders which were cumbersome, repetitive with lots of information which was difficult to navigate. Not all records were personalised with some records containing generic information which had been copied and pasted which resulted in people being referred to by the wrong name and incorrect gender. The majority of information was completed by the provider with little input from people who used the service and relatives and or those important to them.

Whilst we saw that some care plans had been signed by people we found that people had not always been involved in the planning of their care and did not always receive care that was responsive to their needs. One person who had been admitted to the service for respite care 21 days prior to the second day of our inspection still did not have any care plan in place. There was no pre-admission assessment of need other than the local authority assessment within their file. The local authority assessment identified areas of potential risk for this person. This person whilst able to articulate their needs wishes and preferences had not been consulted in the planning for their care. The lack of any plan of care meant that staff, including agency staff did not have any written guidance with actions described to enable them to mitigate risks and meet the assessed needs of this person.

We found for one person who was registered blind their care and support plans did not provide guidance for staff in meeting their needs with regards to their impaired sight and how this impacted on their daily living with actions for staff in meeting their needs. We observed this person to lie on a sofa for the two days of our inspection with some interaction from staff at meal times and when requiring support with their personal care. When referring to their social care needs their care plan stated, 'staff arrange social pursuit outings where I can meet up with friends from other care homes and day services. I like to go bowling, the pub, swimming, listen to music and to play ball.' Staff told us this person did not have access to day services and did not have any friends living in other care homes as stated in their support plan but spent the majority of their time in the home.

Daily notes were detailed but were not monitored for patterns or trends. Hospital passports were in place but were of an old format which did not always contain some essential information. For example, one person had been assessed as requiring a hoist for all transfers, their passport did not contain this information or identify which size sling they had been assessed as requiring.

There was little sign of any meaningful, individualised activities taking place according to people's assessed wants, needs wishes and preferences. People's individual needs for social stimulation, community inclusion and access to group activities were limited. Activities were reliant on enough staff being available to enable people to go out into the community and the shortages of staff meant that people did not always have these opportunities. We observed a group of women who mostly sat in a small lounge over the two days of our inspection, watching TV with little stimulation other than staff painting of their nails and some supported out into the garden. Activities people had taken part in were recorded as 'walking therapy', 'music therapy, listening to favourite music' and 'walking round the lounge in a wheelchair'.

The deputy manager told us that they took responsibility each Monday and planned what activities would be provided for individuals throughout the week and recorded these on a weekly plan. A review of these records showed us that these did not always reflect what was actually provided and on our second inspection visit we found no plans had been produced for that week. Where it had been recorded people took part in a garden party this turned out to be no more than some people sat in the garden for the afternoon. One person more independent had access to a day service for one morning each week to learn cooking skills and another walked to a local coffee shop independently of staff each day. The majority of activities provided included, walking out, shopping, playing a computer game, and for two people occasional swimming. We were not assured that the provider had actively involved people in arrangements for appropriate social activities, and where appropriate education and enabling people to contribute to the planning of their care with their wishes and aspirations fully identified thus enabling people to live as full a life as possible.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the commencement of the service inventories had recorded people's personal belongings such as clothing brought with them when moving into the service. However, these had not been updated to record additional items purchased later such as electrical goods, mobilising equipment that had been paid for from some people's personal monies.

We noted the commissioning local authority contracts described fees paid to the provider included, accommodation, meals, travel, personal care and staffing costs. However, the provider did not have any contract in place for people and their relatives which would describe any of the additional costs that had been charged. We found a lack of information provided to people and other relevant persons as to any information regarding additional costs that may be payable where people may be required to fund from their personal monies activities and equipment associated with their care and treatment. For example, we found people had paid for the use of transport, occasional meals out, snacks and activities. We found information confusing as to how holidays were funded. The provider was unclear when asked as to when people who used the service or the provider had paid for their moving and handling equipment required to keep people safe, such as hoist slings, beds and wheelchairs. This meant that it was not clear how people's access to equipment, holidays and personal care items would be funded.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in day to day management of the service who was also the provider and a director of the service.

Prior to our inspection we received concerning information as to the provider's ability to identify risk and take appropriate action to mitigate the risks to people's welfare and safety. We had received information of concern regarding incidents of alleged abuse against people who used the service. By law providers are required to inform the Care Quality Commission (CQC) of any safeguarding incidents including those being investigated by the police. The provider failed to notify CQC of an incident being investigated by the police as they are required by law to do so. We discussed this with the registered manager during our inspection visit.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager did not promote a culture that encouraged openness, transparency and honesty at all levels. Where inspectors requested information from the registered manager regarding the numbers of staff employed, staffing rotas the numbers of staff living on the premises and people's access to GP's we received inaccurate, conflicting and contradictory information. We also found that staff had been instructed to collude with the provider and avoid providing accurate information to inspectors when requested. For example, when asked about arrangements for staff living in the service, the accuracy of the staffing rotas and the care provided to people.

This demonstrated a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection we found the registered manager had gone on holiday having left the country and designated the deputy manager as the person responsible for managing the service. The deputy manager told us they were uncertain when the registered manager would be returning. Before leaving the registered manager had provided some petty cash to enable the deputy manager to purchase food but had locked filing cabinets containing people's personal money and staff records and left the deputy manager without access to a computer. This meant that people did not have access to their money. Without access to IT facilities for the deputy manager this had left them unable to carry out the full range of duties required, such as access to update care plans, risk assessments and the ability to report to the Care Quality Commission notifiable incidents. The next day after our inspection the deputy manager informed us that the provider had enabled them to access the computer after communicating feedback from our inspection.

Whilst we were present in the service on the second day of our inspection a member of staff employed via an agency arrived at the service to live and work at the service. We were told by the deputy manager this person would be allocated to work immediately on the rota. However, the deputy manager could not verify that

adequate checks had been carried out on this person prior to their placement. We could not be assured that all necessary steps had been taken to verify their suitability to work at the service and evidence all safety checks had been carried out. We attempted to speak to this person but found they were unable to understand what we were asking due to their limited understanding of English and were unable to provide us with the reassurance we needed to assure us safe recruitment and selection processes had been followed.

The provider had a limited governance system in place to monitor the quality and safety of the service. This was inadequate as it did not identify the shortfalls we found and identify the risks to people's safety and welfare. For example, in relation to fire safety, the safe moving and handling of people and the insufficient numbers of skilled and knowledgeable staff, available to meet people's needs at all times.

We found the system in use for auditing the premises and health and safety checks of the service was not fit for purpose. Health and safety audits carried out on a monthly basis consisted of a tick box system which did not relate to checks of specific areas of the building, failed to identify the shortfalls that we found at this inspection and those also identified by the fire officer.

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

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 provider failed to notify CQC without delay regarding incidents investigated by the police following allegations of abuse in relation to a service user.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 Registration Regulations 2009 Fees The provider did not have any contract in place for people and their relatives which would describe any of the additional costs that had been charged. The provider failed to provide terms and conditions which would specify additional costs in support of their care and treatment.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to do everything that was reasonably practicable to make sure that people who used the service received person centred care and treatment that was appropriate, which met their needs and reflected their personal preferences.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against the risks by way of doing all that is practicable to mitigate any such risks. Including the management of the premises, including fire safety, moving and handling equipment and ensuring access to health care support in a timely way.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to take action to mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on the regulated activity.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have safe and effective systems and processes in place and operated effectively when selecting and recruiting staff.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not promote a culture that encouraged openness, transparency, and honesty at all levels.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of competent, skilled and qualified staff available at all times to meet the care and treatment needs of people who used the service.

The enforcement action we took:

We issued an urgent action letter asking the provider to tell us what urgent action they would take to mitigate the risks to people's health, welfare and safety.