Park Avenue Ltd

# Hill House

## Inspection report

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Tel: 01215233712

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This inspection took place on 15 November 2016 and was unannounced. During our last inspection of this service in April 2016, we identified a breach of one legal requirement. This was because systems in place were not effective to monitor and improve the quality and safety of the service that people received. During this inspection, we found that this had not improved.

The home is registered to provide personal care and accommodation for up to 13 people who have a learning disability or autism. At the time of our inspection, ten people were living at the home.

The registered manager had left the service in October 2016 and a new manager had joined the service and was in the process of completing their application to register. 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.

People could not be confident that they would always be kept safe at the home. People were not always protected by safe practices or effective risk management at the home. Appropriate action was not taken to prevent future incidents occurring at the home where people and staff had been put at risk of harm. People could not be confident that they would be supported to use safe equipment or that they would be protected by safe infection control practices.

People were not always supported to receive their medicines as prescribed or to ensure that the correct amounts of medicines were available to keep them well. People were not always supported by staff with the right mix of skills and knowledge to meet their needs.

People were not supported in line with the principles of the Mental Capacity Act (2005). People's consent was not always sought and some people were stopped from moving freely or as they wished around the home. Concerns were not resolved by the manager and some staff had not received training or guidance in relation to the Mental Capacity Act (2005).

Some staff we spoke with demonstrated an understanding of people's needs, however we saw that this knowledge was not always applied in practice. Staff had not been equipped with specific training by the registered provider in relation to people's needs. Staff practice was not led or overseen by the manager or informed by clear guidance.

People were not always supported to eat enough or to maintain a balanced diet to stay healthy. Care had not been taken to plan people's mealtimes so that people's preferences were met in terms of how they were offered choices and ensuring that mealtimes were a positive experience. People could not be confident that they would always be supported to access healthcare support or monitor their ongoing health needs as required to stay well.

Whilst we observed some positive interactions from staff towards people living at the home, this was not consistent practice. Planned action was not taken to meet people's communication needs and staff failed to always address people directly or involve people in their care. Care had not been taken to ensure that people resided in a safe and comfortable environment, we were informed that this was being addressed. Staff failed to promote people's dignity at all times.

People did not always receive care that was responsive to their needs or in line with their care plans. People were not always supported to participate in activities of interest to them. An activity coordinator had recently been recruited and provided examples of how they had supported some people with activities. We saw that people responded positively to the activity coordinator's encouragement and support.

Relatives we spoke with told us they felt comfortable raising concerns and most relatives told us they felt that the manager would act on concerns to improve the service. A healthcare professional told us that they had needed to prompt the manager on occasions before the manager addressed their concerns.

People were not supported by staff who were directed and supported in their roles. The registered provider and manager had not acted on concerns that they had identified about the quality of care people received. The manager failed to maintain oversight of the service and to resolve additional concerns that we brought to their attention during our visit.

People were not supported within a culture that was person-centred. We observed staff disputes and several occasions where people were not approached with respect or in line with their needs. Concerns about staff practice had not been addressed to ensure that people's dignity was promoted or to ensure that people received safe and responsive care.

Within two days of the inspection visit the provider submitted a number of documents related to the inspection findings and we received assurance that action had commenced to address issues of concern that had been raised. We have referred to any such immediate action in the body of the report.

You can see what action we have asked the provider to take at the back of the full version of the 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.

People were not always protected by safe practices or effective risk management.

Action was not taken to prevent future incidents which had put people and staff at risk of harm.

People were not always supported to receive their medicines as prescribed.

People were not always supported by staff who understood their needs.

### Is the service effective?

**Inadequate**

The service was not effective.

People's rights and choices were not always respected and the service did not support people in line with the principles of the Mental Capacity Act.

Staff were not always equipped with knowledge and guidance for their roles.

People were not always supported with their nutritional needs or to access healthcare support when required.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People were not always treated with respect by staff.

People's communication needs were not met to support them to make decisions about their care.

Care had not been taken to ensure that people always resided in a comfortable environment.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People did not always receive care that was responsive to their needs or in line with their care plans.

People were not consistently supported to participate in activities of interest to them.

People were not always supported to have their views and any concerns about their care heard. Relatives told us they felt comfortable making complaints.

## Is the service well-led?

**Inadequate**

The service was not well-led.

People were not supported by staff who were directed and supported in their roles.

Concerns about staff conduct and the care some people received were not always identified and addressed.

Systems to assess and monitor the quality of the service were not effective.

# Hill 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.

This inspection took place on 15 November 2016 and was unannounced. This inspection was conducted by two inspectors.

As part of our inspection, we reviewed the 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 safeguarding matters. These help us to plan our inspection. We approached commissioners for feedback about the home and used this information to help inform our planning.

Some people living at the home were not able to talk with us about their care. During our visit, we spoke with one person living at the home about their care and observed the care of other people living at the home. 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.

During our visit, we spoke with six members of staff, the manager and the nominated individual who is responsible for this service. We also sampled four people's care records, two staff files and records maintained by the service about risk management, medicines, care planning, staffing and quality assurance. Following our visit, we spoke with four relatives and one healthcare professional.

Inadequate

# Is the service safe?

## Our findings

People living at the home could not be confident that they would always be kept safe and well. People were not consistently protected by the risk of avoidable harm through effective risk management and staff's awareness of people's needs. At the time of the inspection, three out of ten people living at the home required wound care.

One person was regularly visited by a healthcare professional who managed their wound with the support of staff at the service and our review of this person's care plan showed that they had an infection. Although a care plan had been established for this person's care, we found that this person had not been supported to reside in a safe, clean environment that helped them to safely manage their infection. For example, the person needed to use dressings to keep their wound clean, however we saw that this person had not been supported to store the dressings safely so that these remained in a clean condition and ready to use, these dressings were left on the person's bedroom floor. We observed that staff did not follow all infection control measures as outlined in this person's care plan. We raised this with the manager who assured us that they would address this with staff and that they had a measure in place to manage this risk, however at a later time during our inspection, we observed a further occasion where staff failed to follow the registered provider's infection control measures. Our discussions with the manager showed that they had not taken steps to ensure that staff were aware of this person's needs, the manager told us, "All staff should have been made aware," however they confirmed that they had not informed staff and they could not tell us how or when staff had been made aware of this risk previously.

Staff were responsible for supporting two people with their wound management, however we could not be confident that their risks were always managed safely or consistently. A staff member we spoke with told us that they had previously raised concerns about one person's wound with nurses on a number of occasions, for example when they had identified signs of infection to the person's wound. The staff member told us, "[A person's] scar was leaking. We've asked nurses why it is leaking, nurses don't seem to always notice or respond consistently when we are worried." Our sample of this person's care plan showed that staff had not routinely monitored this person's wound over time, for example, to assess whether the person's wound was healing or if the person was at risk of infection. There was no guidance available to staff as to how this wound should be managed. This person was at risk of causing further harm to their wound. In order to reduce the risk, we saw that staff supported the person on a one-to-one basis whilst at the home. A nurse told us that staff supported this person and ensured that unsafe objects were out of reach to them. The nurse commented, "[We have to] always be on the ball with everything, speak to [the person], see how [the person] is feeling." Staff we spoke with understood that this person required one-to-one support and the manager demonstrated an understanding of this person's history and needs.

Another person with sore skin had developed a wound over the time they had been living at the home. One nurse we spoke with told us that they supported this person with dressing the wound. Although the person's wound had developed a number of weeks prior to the inspection, no support plan had been established so that all staff were aware of how to treat the wound or to consider that the person might have required pain relief due to their wound. We observed that appropriate care was not taken to support this person to

manage their risk of discomfort or further skin breakdown. The nominated individual provided evidence to show that a care plan about this person's needs had been developed shortly following our visit.

People living at the home and staff had been put at risk of harm due to several incidents occurring where a person had displayed behaviours that challenged. These incidents had not been investigated or addressed to ensure that this person was supported to manage their behaviours or to minimise risks to people's safety. One staff member told us, "There was an incident where [one person] threw a chair, this missed a staff member. We filled in an incident form." One incident record stated, 'It was lucky that the [object thrown by the person] did not hurt [another person living at the home].' There had been another incident where the person had assaulted a person living at the home, this incident had not been reported to the appropriate authorities. Action had not been taken to investigate these incidents, to safeguard people living at the home.

Our sample of incident reports at the service showed that incidents had not been investigated to ensure that appropriate action was taken to support people at the time of these incidents or to prevent similar occurrences in future. We could not be confident that this person received appropriate support from staff to manage their behaviours. One staff member told us, "We're not supposed to shout or tell people off but what's in place to show [us] what to do?" Staff had completed records to reflect incidents that had occurred, incident records we reviewed contained inappropriate language and descriptions about how they had supported this person to manage their behaviours. The manager told us that they had previously identified that staff descriptions of the person's behaviours showed a lack of staff understanding of the person's needs. However, the manager had taken no action to equip staff with this knowledge. We found that this had a poor impact on the person's care through our observations of how they were supported when they displayed behaviours that challenged during our visit. Following our inspection, we were made aware of a further number of incidents where people living at the home had been put at risk of harm. After the inspection the nominated individual provided evidence that visual aids were available at the home to help people to express their feelings and manage their behaviours, during the inspection we saw no evidence that these were used by staff at the home and no staff made particular reference to them. Following our inspection, the nominated individual told us that they had conducted a review of behaviour support plans. The nominated individual also assured us that more detailed analysis of incidents would be conducted with the support of other healthcare professionals.

People were not always supported to use personal mobility equipment safely. Although recent maintenance checks had been conducted on some equipment at the home, and a list provided of such tasks that had been reported and acted on the registered provider had failed to identify that people did not always have access to safe equipment. We saw that parts of one person's wheelchair were missing. We asked a staff member about this, who told us that they had already raised concerns about this person's wheelchair with the nurse, however we found that no action had been taken to address the issue. The staff member told us, "I wouldn't want it [to sit uncomfortably with unsuitable support]." We raised this concern with the nominated individual who had not been aware that parts of this person's wheelchair were missing. The nominated individual told us that after our inspection they had located missing parts of the wheelchair, to help this person to use their wheelchair safely and comfortably. We saw that another person used a mobility frame, however we identified that parts of this equipment were also missing. We raised this with the manager who informed us after our inspection that these issues had been resolved.

Failure to provide care and treatment in a safe way for people and to do all that is reasonably practicable to manage people's risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not supported to take their medicines safely or as prescribed. We observed that one person

was experiencing discomfort from a sore eye. When we sampled this person's medicines records, we found that although this person had been prescribed a number of eye drops, not all of the medicated drops were available. We asked a nurse about this who told us, "Maybe they need to reorder it," however it was unclear who at the home was responsible for reordering medicines on behalf of this person. We queried this with another nurse who told us, "I haven't questioned it to be honest." A healthcare professional we spoke with told us, "We have found it difficult to get staff to order one person's prescriptions." Following our inspection, the nominated individual informed us that this person was being supported to access healthcare support for their eye condition. We also received copies of records about eye care for another person. This demonstrated that while evidence was not available at the time of our inspection, routine healthcare issues including eye checks had been undertaken.

Another person living at the home had been prescribed medicines that required regular blood tests to ensure that the dosages prescribed were safe and effective. The person had not been supported to undertake these blood tests with the frequency required and we could not be certain that the medicines being given were effective. The registered nurse and manager of the home were unable to explain why this support had not been provided and they were unable to demonstrate whether sufficient action was taken to meet this person's needs at the time of our inspection. The nominated individual provided us with an update shortly following our inspection to advise that they intended to review this person's care and take action to meet this person's needs.

Records showed that where one person had regularly refused their medicines, this issue had not been explored with the person or followed up by staff. When we asked the nurse leading the shift whether this issue had been followed up with a doctor, the nurse told us, "I'm not sure, not by me." We shared our concerns with the manager and the nominated individual about the medicines management practices at the home and they assured us that this would be addressed. People's medicine records were not always completed clearly or correctly. For example, one person's medicines records had a number of recent gaps which meant that we could not be confident that this person had received their medicines on these occasions. We asked the nurse how this person's medicines records were checked to assess whether the person had received their medicines safely and the nurse told us that they were "Not sure," about this process. Our random sample of people's medicines found that incorrect quantities of medicines in storage at the home which did not correspond with people's medicines records. We found that some people had more medication in storage than was expected from records, which indicated that people had not been supported to take their medicines as prescribed. People's medicines were not stored safely or securely and we found that some people's medicines were left on the floor due to insufficient storage space, which reflected a poor system for managing medicines and increased the risk of medicines errors. The nominated individual told us that they had booked a medicines audit with an external senior pharmacy following our inspection and that they would continue to monitor medicines management at the home.

Failure to ensure the proper and safe management and supply of people's medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Relatives we spoke with told us they felt that people were safe using the service. One relative told us, "From what I see my relative is quite safe… [My relative] is very vulnerable but everything looks fine." Most staff had been supported to complete safeguarding training to help staff understood processes to keep people safe from abuse. Staff we spoke with told us how they would recognise safeguarding concerns and told us that they would report concerns to the manager. One staff member told us, "If people really were in danger, I'd step in."

We saw that there were enough staff available to support people. One staff member told us, "We have to

keep an eye on people all the time. There is always someone providing one-to-one care [for some people living at the home]." We saw that people who required one-to-one support were provided with this. The number of people living at the home had increased since our previous inspection and additional staff had been recruited to support them. Relatives and a healthcare professional we spoke with told us they felt that there were enough staff to support people at the home. A relative told us, "There are always a lot of staff around." A healthcare professional told us, "There are probably enough staff." A staff member told us that staff attendance had recently improved at the home which meant that less agency staff were used, and that the manager occasionally used agency staff who had worked at the home previously. Our discussion with the manager confirmed this and the registered provider showed that they monitored their use of agency staff and were satisfied that use of agency staff at the service was not excessive.

Although the registered provider had established a process for recording recruitment processes and decisions at the home, this was not effective for ensuring and demonstrating that suitable recruitment checks were always completed. One staff member we spoke with told us they had completed a Disclosure and Barring Service (DBS) check before they commenced in their role, records we reviewed confirmed this. However this person's reference checks, to assess the staff member's suitability for the role, had been completed after they had commenced in their role. The manager had completed documentation to indicate that they had followed the registered provider's process in completing reference checks for this staff member, however we found that they had not done so. In addition for another staff member there was no evidence that suitable recruitment checks and risk assessments had been conducted before they commenced in their role and this had been identified by the registered provider. At the time of the inspection it was unclear whether both reference checks had been completed for this staff member as required by the registered provider as this information had not been recorded.

People could not be confident that their finances would always be managed safely at the home. Records we sampled showed that staff had not always followed the registered provider's processes to keep people's money safe. For example, staff had not always followed the process of recording how much money people had taken out of the home and returned, and staff did not always sign records as required to show that they had witnessed people's money being handled at the home. The manager agreed with our finding and told us that this would be addressed.

Inadequate

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us that they had completed DoLS applications for all people living at the home because they had wanted to be transparent and ensure the process was followed correctly. However the manager had not taken appropriate steps to ensure that people were supported in line with the principles of the MCA. Two people's DoLS applications had been authorised, however the manager could not clearly explain the purpose or conditions for these authorisations. Although the registered provider assured us that they had provided most staff with training and guidance in this area, we observed that staff did not reflect an understanding of the principles of the MCA in practice when supporting people. The manager had not resolved concerns where they told us that they had identified that some people were not supported in line with these principles.

On two occasions, we observed that staff handled a person's mobility aid to move and direct this person around the home, without informing the person in advance. On both occasions, this caused the person to move unwillingly and at a pace that did not meet their needs or help to keep them safe. Staff failed to seek this person's consent in respect of this support and whether the person wished to move around the service. We observed on these two separate occasions that staff handled the person's mobility aid to make the person stand up, without having sought the person's consent in advance. Where upon standing, this person demonstrated some choice in moving towards one part of the communal area, we observed that staff then steered this person towards another direction of the communal area on both occasions, in line with the staff member's own choice as to where the person moved. We raised our concerns about this practice with the two staff members in question, both staff members had not recognised that this practice failed to promote the person's rights to make choices and to consent to the support that they received.

Another person living at the home was subject to unlawful restraint that failed to maintain their dignity or enable them to move freely as they wished. We observed that one staff member restricted this person through various means, for example, by blocking the door when the person tried to leave the lounge area. The staff member held this person by their clothing in a manner that prevented this person from moving freely despite the person's attempt to do so. We observed that other staff members expressed concerns about this staff member's practice. One staff member told us, "[I've told this staff member], 'Don't handle the person that way, I know you can [support this person] in a better way.'" Our discussions with the manager showed that although the manager had been aware of these practices and had addressed these

concerns with the staff member previously, they had not taken sufficient action to ensure that such practice was ceased, to promote this person's rights and dignity. Although the manager informed us during our visit that this person had a DoLS authorisation in place, we identified that this person was subject to restrictions that were beyond the authorised care and support to protect this person and were not in line with the principles of the MCA.

Failure to seek or obtain the consent of people who use the service and act in accordance with the requirements of the Mental Capacity Act (2005) is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff we spoke with demonstrated an understanding of people's needs and the registered provider showed us records to reflect that the staff group had experience of working in the care sector. One person told us, "Staff are good." A nurse told us, "I'm getting used to [people's] needs", and commented that they felt supported in their role. We found however that people were not supported by staff who were consistently equipped with the skills and guidance for their roles. One staff member told us, "I feel equipped in my role. Some staff don't feel supported, who don't have a background in care." Staff had not been supported with specific training from the registered provider which was tailored to the needs of people living at the home, for example, in relation to behaviours that challenged.

Our observations and discussions with staff showed that staff were not consistently equipped and directed in their roles to meet people's needs. A staff member told us that there was no guidance to equip staff to help one person to manage their behaviours. Sufficient action had not been taken by the registered provider to ensure that this person was supported in a way that reflected their needs and preferences. Records showed and the manager confirmed that another person living at the home regularly displayed behaviours that challenged. We observed an incident involving this person and found that most staff and the manager failed to effectively support this person. We asked staff about this incident and one staff member told us, "It would be good if the person had a protocol for [when the person displays behaviours that challenge]. I didn't know what to do when the person was upset… I hated feeling so helpless." Another staff member told us, "Everyone [staff] has a different approach about how to deal with this. I'm not sure what's right. I've never seen this written down." We observed that the manager did not lead a compassionate or effective approach in supporting this person to manage their behaviours. Where the person showed signs that they were distressed following an incident where they had displayed challenging behaviours, the person was not given support or reassurance by staff or the manager. We raised this concern with the nominated individual who had independently identified that this person was unhappy, and they showed the person some appropriate care and concern to help alleviate the person's distress.

Following our inspection, the nominated individual assured us that they would hold a workshop with staff to ensure that staff were fully aware of the needs of each people living at the home. Records we sampled showed that most staff had been supported to complete basic training for their roles, including training in health and safety, infection control and food hygiene. Where the registered provider had not provided training to staff in these areas, training had been scheduled to ensure that staff remained aware of good practice. We found that some staff were new to their roles and had not received training from the registered provider about how to meet people's specific needs. The manager informed us that all staff were due to receive training from an external training provider, including training in relation to supporting people with mental health needs, handling information, infection control, challenging behaviour, communication, safeguarding and MCA.

The registered provider told us that staff were supported to complete the Care Certificate, which is a set of minimum care standards that new care staff must cover as part of their induction process. The manager

provided evidence to show that they had requested for some staff to receive this induction training and the nominated individual assured us that this was regular practice. Our discussions with staff however showed that they had not been supported to complete a full induction to equip them in their roles. One staff member described their induction, "I got shown around and did some shadow shifts." The staff member told us that they had not received any training from the registered provider since they had commenced in their role and confirmed that they did not have any previous experience of supporting people with learning disabilities or autism. A nurse told us, "I've done [my induction] myself, it was me reading care plans… and a chat in the office for an hour." The registered provider showed us records to reflect that staff had been supported with a practical induction of the service and had received training. However we saw occasions and were told by some staff that that they did not know about the specific needs of some people and did not know how to respond to meet their specific needs.

Failure to ensure that staff are suitably competent and skilled to meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not always supported to eat enough and maintain a balanced diet to stay well. Our discussions with the home's chef showed that they did not understand the nutritional needs of all people living at the home. Records we sampled showed that staff did not routinely monitor the food intake of two people living at the home as required to help them to stay well where this had been assessed as required due to their needs. We spoke with the cook at the home who confirmed that there were insufficient foods available at the home to support people to prepare healthy small meals and snacks throughout the day. We observed that one person ate all of their meal and showed that they enjoyed this. A relative told us, "Staff always get [person] a drink if they want one."

Arrangements were not made to ensure people always enjoyed mealtimes at the home. Some people were not offered choices about their meals with respect or in a format that they could understand, such as visual prompts. The nominated individual told us that although we did not see them being used visual aids were available at the home to help people to communicate and assured us that these would be shared for use with people living at the home. When one person was not able to respond promptly to a staff member we observed that the staff member did not demonstrate concern or consideration in how they approached this person. They gave the person little time to make a choice about their meal when they just repeated the meal options again. Another person was offered their meal choices from a staff member who rushed this process as they were busy with other tasks. We observed that practical arrangements were not made to support one person to remain relaxed during their mealtimes and to manage their specific needs associated with a condition. This showed that the registered provider had not given full consideration or made suitable arrangements to meet this person's needs. A staff member we spoke with described the negative impact this had on the person's mealtime experience. The staff member told us, "It was a flash point for [the person] today waiting for their meal." We observed that staff disputed with one another during people's mealtime about how best to support this person. This contributed to a poor atmosphere during people's mealtime.

People could not be confident that they would always be supported to access healthcare support as required to stay well. People's symptoms were not always monitored as required to meet their needs. We observed that staff did not explore one person's needs in a timely way when they reported that they were experiencing pain during the morning and afternoon of our visit. The person was given pain relief after a number of hours and following a number of occasions where they had told staff that they were experiencing pain. Staff interactions we observed with this person showed that they had not fully explored this person's needs in a timely way to ensure the person stayed well and comfortable.

A healthcare professional had requested for staff to monitor another person's blood sugar levels to assess

the possibility that this person had a specific health condition. We found that this action had not been taken to support this person's assessment for three months at the time of our visit. A healthcare professional told us, "We asked continually for one person to have [tests they required to monitor their health needs] and they were never done. We needed to continue to ask."

One relative told us, "[Person's name] goes to the doctors when they need to." The manager informed us that people living at the home had been registered at a new general practice and that a doctor would be supporting people with ongoing health checks.

Requires Improvement

# Is the service caring?

## Our findings

People were not always addressed or treated with respect by staff. We observed occasions where staff talked loudly about people's support needs in the presence of the person and other people living at the home. For example, staff loudly discussed one person's personal care needs in the presence of this person and other people in a communal area of the home, this did not respect this person's privacy.

People's communication needs were not met to ensure that they were always involved in decisions about the care and support they received. For example, during a mealtime, staff pointed at one person who was sitting nearby and asked staff if this person had received their food and drink, without addressing the person directly. We questioned a staff member about an occasion we observed where another person was not supported to make a choice or understand the support they were receiving. The staff member confirmed that they had not spent time communicating with this person in a way that met their needs to ensure that they were aware of what was happening. The staff member told us, "Maybe [staff] need to use pictures and slow down the interaction so [the person] understands." Another person's care plan provided generic guidance as to how staff could communicate effectively with the person, for example, instructions for staff in relation to meeting the person's communication needs stated, 'Employ tools and strategy to help understanding.' Some people living at the home had been supported to complete surveys about their care. The activity coordinator confirmed however that not all people's communication needs had been met so that everybody living at the home had the opportunity to share their feedback. We found that the registered provider's plans to ensure that staff understood how to support people to express themselves were not followed at the time of our inspection.

We saw that some new furniture had been supplied and was being used in a communal area of the home, however action was needed to ensure that people had a consistently safe and comfortable environment. We were informed the radiator in the room was broken in a bedroom. One person had invited us to see their bedroom and we were concerned to note that the temperature of this person's room was very low. This person also had broken furniture in their room and we saw that their bedding and other belongings were stored in boxes and large plastic bags. We found that the blinds in this person's room were damaged and did not fully block the light from outside. A staff member confirmed our observations and informed us that a new heater and furniture had been ordered for this person to use in their room. We were advised that a separate heater was available in the meantime. We saw that the belongings of another person who had lived at the home for a longer time, were also stored in boxes and large plastic bags. A staff member told us that there had not been enough bedding resources for people living at the home for a long period of time to ensure they were always comfortable. The staff member told us that this issue had been raised with the manager and although addressed the staff stated that action was not timely. Another person living at the home invited us to see their bedroom and we saw that this person had suitable bedding. Following our inspection the nominated individual supplied us with an extract from the maintenance log to show that some maintenance issues had been identified and completed. The registered provider assured us that they were continuing to address other issues to help ensure that people were supported in a comfortable environment.

We observed that the main communal area of the home was poorly lit. On one occasion, a person ate their meal in a dark corner of the home which had no lighting and this was not addressed by staff. We queried this with the manager who explained that the home was often poorly lit because staff seemed to have a habit of turning off the lights. The manager had not investigated this with staff however. We observed during our visit that staff and the manager did not explore or consider people's choices in respect of lighting in their home.

People were not always treated with respect and staff failed to promote people's dignity at all times. One person living at the home had not been supported to wear suitably fitting trousers. This person's trousers fell down which exposed the person's legs and underwear in front of other people living at the home and staff. Staff responded to this incident by loudly questioning why this person had not been supported to wear a belt. Staff did not provide any reassurance or an apology to this person and assisted them to put on a belt to secure their trousers whilst they remained in the communal area in the presence of other people. A staff member commented, "That belt should have been added [when the issue] was noticed [when the person was supported to dress]." We observed that whilst staff supported another person living at the home to move into a chair, staff failed to maintain awareness of this person's dignity by ensuring that this person's underclothes were covered. The staff members supporting this person did not recognise this as a concern and did not take other appropriate action to ensure that this person was supported to sit comfortably and in line with their needs and preferences.

Failure to treat people receiving care and treatment with respect and dignity at all times is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed some kind and respectful interactions from staff towards people living at the home. People responded well to these interactions and showed that they enjoyed them. We saw that staff often checked whether some people were comfortable and well. A staff member told us, "[I always say] is this how you would want your family treated," and described how they supported people living at the home. Relatives and a healthcare professional we spoke with told us that they felt that staff were kind and caring to people living at the home. One relative told us, "[Staff] seem to be quite good with my relative." Another relative told us, "Staff are kind and caring. [My relative] has their favourites and lets you know who they are… [Staff] are all nice, all the time."

Requires Improvement

# Is the service responsive?

## Our findings

A staff member told us, "People get good support from us, their individual needs are well met." We observed however that people did not always receive care that was responsive to meet all of their needs. Relatives we spoke with told us that they had been asked about people's needs and that they had been involved in care planning when their relative first joined the service. One relative told us, "All staff seem to know about my relative and idiosyncrasies." Although people's care plans provided details of their hobbies and interests, care plans we sampled were not always updated to reflect people's current needs. For example, one person's care plan had not been updated to inform staff of how to support this person with a specific health condition or other ongoing needs and risks to this person. We observed that staff had failed to effectively manage a risk to this person during our visit. A staff member told us, "[Care plans] which are complete are detailed, many are still a work in progress." Following our visit, the nominated individual assured us that they would review each person's care plan to ensure this met their needs and demonstrated that care plans were in place to provide staff with specific information about people's needs.

We looked at the opportunities people had to do the things they enjoyed. One person told us that they were supported to participate in activities of interest to them, which included going out, shopping, going to the park and sightseeing. We saw that staff supported another person with their reading. An activity coordinator had recently been recruited. Relatives and a healthcare professional we spoke with provided positive feedback about the activity coordinator's support and approach with people living at the home, we observed this in practice. A healthcare professional provided us with a positive example of how one person had been encouraged by the activity coordinator to participate in activities that promoted the person's health and wellbeing. The activity coordinator told us that they supported another person to go swimming and to access a sensory room within the community because this person enjoyed these activities. The registered provider supplied us with positive written feedback they had received from another healthcare professional, which described the positive impact that the activity coordinator had on the service and how they had engaged people in activities of interest and meaning to them.

People could not be confident however that they would always be supported to participate in activities of their choice. The activity coordinator told us that they had spent time with some people to gather their views about their care and the types of activities they enjoyed. Records showed and the activity coordinator confirmed however that people who could not express themselves verbally had not been supported to share such feedback in a way that met their communication needs. Our discussions with the manager and activity coordinator showed that the activity coordinator made decisions about people's activities on a daily basis, rather than supporting people to decide what activities they wanted to do. This meant that people were not always supported to go into the community when they wanted to. The manager explained that one person had displayed behaviours that challenged because, "Perhaps it's not [the person's] turn to go out." We found that another person living at the home had not been supported to access their finances in a timely way, which had prevented the person from going into the community with other people as they had wished and led to the person displaying distress and behaviours that challenged. Following our visit, the nominated individual informed us that they were continuing to take steps to support this person to access their finances.

During our visit, we observed that most people participated in group activities together at the home, such as preparing healthy fruit drinks together. Two people living at the home chose to spend time in their rooms. We observed that two people who spent time in communal areas of the home were not always given the opportunity to decide whether they wished to participate in activities taking place at the home. For example, one person had not been invited to participate in an activity with other people at the home during our visit. We observed that a staff member commented to the person after the activity had concluded that the person would have been welcome to join in, however no effort was made to involve them at the time. We observed that another person was encouraged on a number of occasions by staff to participate in this group activity. Although this person clearly declined this offer each time they were asked by staff, staff continued to encourage this person until they joined in with the group activity. We observed that this person left the group activity after a short period of time and that the person remained unhappy. This person was not asked by staff about what activities they wanted to do or how they wanted to spend their time. We saw that the person was not supported to do any alternative activities of interest to them at this time.

Relatives we spoke with told us that they would feel comfortable raising complaints at the service with the manager. Most relatives we spoke with felt that the manager would act on their concerns to improve the service. One relative told us, "We're able to raise complaints… they would act on concerns." Another relative told us, "I imagine the manager would do something to help." The manager told us that there had been no complaints made about the home. Whilst it was positive that this was the experience of people's relatives, improvement was required as to how feedback was gathered from people living at the home. Some people living at the home had been asked for their views and feedback about the care they received, however guidance about how people could share feedback or complain on an on-going basis was not available to people at the home.

Inadequate

# Is the service well-led?

## Our findings

During our last inspection in April 2016, we identified a breach of regulation because systems to monitor the quality and safety of the service were not effective. Areas of improvement and development at the home had not always been identified and addressed. Following our inspection in April 2016, the registered provider had written to us to tell us how they would improve. We found however that the registered provider had still not taken effective action to meet this regulation at the time of this inspection.
The registered manager had left the service in October 2016 and a new manager had joined the service and was in the process of completing their application to register.

People were not always supported by staff who understood and safely met their needs, however these issues had not been identified or addressed in a timely way by the registered provider or manager, to keep people safe and well. People's risks were not consistently well managed and there were occasions where staff failed to maintain people's dignity. We observed that the manager and nurses who were responsible for leading people's care at the service did not promote a positive culture based around the needs of people living at the home. The manager and nurses did not oversee the quality of care that people received or ensure that staff always supported people appropriately and in line with their needs.

People were not supported by staff who were directed in their roles to safely meet people's needs. We asked a staff member about teamwork at the home and they told us, "Some staff work better together than others. [Some staff] don't always like being told what to do." A staff member told us that a nurse allocated tasks to staff, for example, to inform staff who they would be supporting during their shifts at the home. We identified that this instruction had not been followed by one staff member throughout their time on shift and the staff member had chosen to spend a number of additional hours with one person. We brought this to the attention of the manager who had not identified or addressed this issue. Our discussion with this staff member showed that on one occasion they had previously gone out of the home and into the community with one person, without practical arrangements having made by the manager or staff, so that this person was supported safely with access to food and appropriate transport. Another staff member told us, "Allocations are done well but I'm not always certain it is followed through."

We observed staff disputes during our visit which created an unsettled and poor atmosphere for people living at the home. One staff member we spoke with told us that there was "Confrontation" between staff because concerns that they had raised with the manager about people's care and the practice of other staff members had not been listened to. The staff member commented, "In my experience, what's the point of speaking up… we've realised we're not listened to." On one occasion, we saw that a staff member greeted a person loudly and with warmth, to which this person responded positively. Another staff member, whilst ignoring the person and their response, disrupted this positive interaction by challenging the staff member in front of this person and stating, "Why are you being so loud." This undermined the positive interaction we had seen and showed that staff did not consistently promote a caring approach towards people living at the home.

We had received assurance from the registered provider prior to our visit, that they were addressing areas of

concern that they had identified at the home to improve the quality of care that people received. We found however that such action had not been taken in a timely way and the manager had not maintained an oversight of areas of concern, for example by managing people's medicines and monies safely and improving how people were supported to communicate. A healthcare professional we spoke with told us that they had raised some issues with the manager and that they had needed to prompt the manager to address their concerns before this was done. The registered provider had failed to monitor and support the manager's progression through the action plan and we brought several examples to their attention as to how actions outlined in this plan had not been met. A staff member told us that there were, "Lots of little issues [at the home] creating one big problem." A healthcare professional we spoke with told us, "There are lots of little things that [the registered provider and manager] really ought to pull together." Following our inspection, we received assurance and updates from the nominated individual about how the quality of care that people received would be improved.

We found that although the manager was already aware of some concerns that we raised during our visit, they had not taken action to address poor staff practice. For example, the manager was aware that some people were not always supported to move freely and safely around the home in line with their rights and wishes. The manager shared our concerns about the inappropriate descriptions staff had used when reporting incidents at the home and agreed that these descriptions showed that staff did not always understand people's behaviours and how to support them. However, the manager had failed to equip staff with the knowledge and skills necessary to support people effectively, and failed to oversee practice at the home to challenge the inappropriate care and support that some people received. We observed one incident occurred at the home where a person became distressed and found that the manager failed to lead the staff team in a compassionate and effective approach to meet this person's needs. We identified another occasion of where the manager did not ensure that they had a shared understanding with staff of key risk and responsibilities to protect people. We raised immediate concerns with the manager that the registered provider's infection control practices were not being followed to protect people living at the home. We observed later during the inspection that the manager had failed to act on our earlier feedback and people were still not protected by safe practices. We found that this ongoing risk to people had not prompted the manager to ensure that appropriate processes were followed or understood by staff.

Failure to assess, monitor and improve the quality and safety of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff we spoke with told us that they felt supported in their roles. A staff member told us, "The job is a challenge, we are always learning." Another staff member told us, "We have contact with the manager, they are either on call or here [at the home]." Other staff we spoke with told us that they were aware that the manager was very busy and a healthcare professional we spoke with told us that the manager was not always available to speak to.

The manager told us that they had distributed staff surveys, to gather feedback from staff about their roles and to drive improvement at the home. The manager told us that they had received a low response to the staff survey at the time of their visit. The manager informed us that they intended to prompt staff to return their surveys. The registered provider informed us that they had not conducted any quality assessment visits to the home because they had already issued the manager with an action plan outlining areas for the manager to address. The registered provider told us that the manager was provided with supervision to support the manager in their role.

The manager had not demonstrated an awareness of their responsibilities to the Commission because they had failed to report an incident to the local authority and to the CQC as required. We found that an incident

had occurred at the home where one person had been put at risk of harm. Although the manager stated that they considered this incident to be reportable to the local authority and to the CQC, they had not taken this action to help protect people living at the home.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered provider failed to treat people receiving care and treatment with respect and dignity at all times. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider failed to seek or obtain the consent of people who use the service and act in accordance with the requirements of the Mental Capacity Act (2005). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider failed to provide care and treatment in a safe way for people and to do all that is reasonably practicable to manage people's risks. The registered provider failed to ensure the proper and safe management and supply of people's medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider failed to assess, monitor and improve the quality and safety of the service. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered provider failed to ensure that staff are suitably competent and skilled to meet people's care and treatment needs. |