Isle of Wight Council

Carter Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 February 2018 and was unannounced.

Carter Avenue is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Carter Avenue is a local authority run care home which provides accommodation for up to six people with learning disabilities and Autism who need support with their personal care. At the time of our inspection there were three people living in the home.

The home was arranged over two floors with most of the bedroom accommodation on the first floor. There were bathrooms available to people on each floor. There were three communal areas in the home, which were a kitchen, a dining room and a lounge.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager was not present during the inspection but a senior staff member was available.

The last comprehensive inspection of this service was in September 2015 when the service was rated Good. At this comprehensive inspection we found the service was not meeting legal requirements and required improvement.

There was a complaints procedure in place to enable people to raise complaints about the service. However, low level complaints were not being captured and information was not presented to people in a way they could understand.

Quality assurance systems were not always robust to monitor and review the quality of the service which was provided. These had not been used effectively to identify concerns we found or drive improvement in the service.

Records of the assessment of people's ability to make some informed decisions had been undertaken. However, the principles of the Mental Capacity Act 2005 were not being applied in respect of best interest decisions to provide care. Staff we spoke with had a variable understanding of the Mental Capacity Act 2005.

People and their relatives were not regularly involved in the assessment and the on-going reviews of their care. Care plans were not written in a way that would enable people to understand and be involved in decision-making.

Staff received training; however, some training to meet specific needs had not been provided.

People received their medicines as prescribed. However, we identified some areas where improvements could be made to ensure the safe administration of medicines and of topical creams.

Families told us they felt their relatives were safe at the home. Staff understood their roles and responsibilities to safeguard people from the risk of harm. Staff knew how to identify, prevent and report abuse.

Plans were in place to deal with foreseeable emergencies such as fire risk; staff we spoke with said they had had received training to manage such situations safely.

People were supported to maintain their health and well-being. Staff supported people to attend appointments with healthcare professionals. People were encouraged to eat healthily and staff made sure people had enough to eat and drink.

People did not have many opportunities to take part in activities within the local community.

Risk assessments that related to people's health and safety were effectively assessed. Action had been taken to reduce identified risks to help ensure the safety of people.

Staff received regular and meaningful supervision and staff had an opportunity to voice their individual views.

We received some positive feedback about the care staff and their approach with people using the service.

Relatives and external health professionals we spoke with were positive about the service people received and people's visitors were welcomed.

People's relatives felt confident to approach the staff or registered manager and felt they would be listened to.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough staff deployed to keep people safe and manage risks.

Safe recruitment procedures were not always in place and not all pre-employment checks had been undertaken.

Medicines were not always managed and administered safely.

Staff were aware of their responsibilities to safeguard people from the risk of abuse. People and their families felt the home was safe.

Infection control risks were managed safely.

Risks to people's health and safety had been assessed and were usually managed effectively.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights and lacked understanding of The Mental Capacity Act.

Staff were not always provided with training to meet the needs of people.

Staff were provided with supervision and appraisals from the management team.

People had enough to eat and drink.

People had access to health professionals and other specialists if they needed them.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always ensure people were treated in a dignified way.

People and their families were not always involved in planning the care and support they received, although people were enabled to make some day-to-day choices.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

Staff supported people to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was responsive.

People had up to date Care plans.

Information was accessible to people although this was being developed further.

People were not always supported with regular meaningful and person centred activities.

Care plans had been developed and reviewed, but people and their families were not always involved in the reviews.

Some staff had received training in end of life care; however, people's end of life wishes were not recorded

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had failed to provide support to the registered manager to enable them to manage the service effectively.

People and their relatives felt the home was well-led, however they were not asked for their views about the service by the registered manager.

A quality assurance process was in place, however, this had not identified all the areas of concerns we found.

There was an open culture within the home and staff told us they felt able to raise concerns.

Staff understood their roles, were motivated and felt valued by the management team.	

Carter Avenue

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 27 and 28 February 2018 and was unannounced. The inspection was undertaken by two inspectors on the first day and one inspector on the second day.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We engaged with three people, who communicated with us verbally in a limited way. We were unable to have coherent conversations with all people living at the home due to their learning disabilities. We observed care and support being delivered in communal areas of 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.

We spoke with three staff members, the provider's group manager, the nominated individual, and the senior staff member. We spoke with one family member and one external professional. We looked at care plans and associated records for three people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in September 2015 when it was rated as Good.

Requires Improvement

Is the service safe?

Our findings

People appeared safe and were relaxed in their home. A family member told us "I feel [person's name] is safe, they have put [hand] rails up to help them when moving in the house." They added, "The staff know them well and know what to do." However, we were concerned that there were not always enough staff to keep people safe.

There was a duty roster system in place which detailed the planned staff cover for the home. The senior staff member told us that short-term staff absences were usually covered by the existing staff team. One staff member told us, "There is absolutely not enough staff for the high level of work that we have to cover." Another told us, "There are not enough staff, it's really, really difficult, staff need more time with people; they rush about all of the time."

Staffing levels meant that people were not getting out into the community regularly. One staff member told us that people used to access day resources in the community but this had stopped. Staff told us that it had been difficult to get people out into the community due to their physical needs and not having enough staff if one person did not want to go out. We discussed the challenges of people being supported to participate in activities in the community with a senior staff member. They told us that people had not been going out as much during the winter months, but they were trying to improve this and to offer more activities and involvement with the local community.

We saw that one person had recently been assessed as needing additional support due to their changing needs. They required the direct support of one staff member for several hours each day. The staff told us that they had to monitor the person throughout the day as part of an on-going assessment. The additional support required was being provided within the existing staff team for each shift. This meant that there was only one member of staff to support the other two people. A staff member said, "I feel like a lot of people aren't as confident working here so a lot of work is left for me to do. Sometimes I feel like going home and crying, a lot is put on me and there is so much to do." The level of support required by the people at Carter Avenue meant that they were not always provided with adequate staffing to meet their needs and keep them safe. One external professional said, "The support staff can give is limited by the amount of staff members they have." We discussed this with the senior staff member and the provider's representative on the first day of the inspection. We were told that an additional staff member had been requested but had not yet been agreed. On the second day of the inspection the nominated individual for the provider told us that one additional staff member had now been agreed. This would enable direct support to be provided to a person who required it and staff would have more time to spend with people and support them with activities. This was effective immediately.

There were appropriate arrangements in place to obtain, store, administer, record and dispose of unused medicines. Staff who administered medicine had been suitably trained and had been assessed as competent to do so. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. We observed staff administering medicines to people in a patient manner, and informing people what the medicine was. However, there was

no system in place to help ensure topical creams were not used beyond their expiry date. In addition, we saw that one entry on the Medicine Administration Record (MAR) was not signed. Although the error had been recognised at the end of the shift by the audit process, no action was taken to check that the medicine had been administered and the MAR signed. This meant that the staff could not be assured that the person had received their medicine or not.

People were prescribed 'as required' (PRN) medicines. There were guidance sheets for staff about when to administer medicines for pain relief. These included information about any changes in the way people looked or in their behaviours, which might indicate they were in pain and required their PRN medicine. However, not all records relating to the administration of PRN medicines were clear. One person required some medicine at times to support them with feeling unsettled. However, there were no clear guidelines in place for staff to know what they should do to support the person to feel calmer prior to administering the medicine, or at which point they should give the medicine. We discussed this with the senior staff member who told us they had seen guidelines but were unable to access them as they were stored on the registered manager's computer. Therefore we were unable to be reassured that this person's PRN medicine would be administered safely and only when needed.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's business support team in conjunction with the registered manager. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions and helps prevent unsuitable people being employed. We looked at three staff recruitment files and saw that one file did not contain a DBS record. In addition, the same recruitment file only contained one reference. References enable an employer to check the applicant's past performance and behaviour when considering them for work with vulnerable adults. The provider was able to provide the missing information after the inspection, as it was stored at a different location. Recruitment processes and where information is stored were discussed with the provider's nominated individual who agreed to ensure that all appropriate information was contained within staff recruitment files in future.

The provider had appropriate policies in place to protect people from abuse. Staff and the registered manager had received safeguarding training and staff told us they knew how to raise safety concerns and understood their responsibility to keep people safe from abuse. The staff we spoke with knew how to keep people safe and report any concerns or incidents. We saw that safeguarding referrals had been made to the local authority. Providers are required by law to notify CQC of significant allegations that occur in registered services. This allows CQC to monitor occurrences and help keep people safe. We saw that safeguarding incidents had been reported to us when needed. Risk assessments had also been developed as a result of some of the incidents to consider ways to reduce the likelihood of a reoccurrence.

Risks to people had been assessed. We looked at three care files and saw clear risk assessments, which explained actions staff needed to take in order to mitigate the identified risks. For example, one person was at risk of falls and there was guidance for staff on how to support the person to reduce the risks. Another person had been assessed as needing a fluid thickener for drinks. Fluid thickening powder is prescribed for people who are at risk of choking and aspiration pneumonia due to a decreased ability to swallow normal fluids. The staff we spoke with were aware of the risks fluid thickening powder poses to people if eaten dry and not mixed with a drink. We saw a robust risk assessment around how to use this and how to store it. There were also guidelines about how to support the person when eating and drinking in order to reduce risks.

Environmental risks had been assessed and were monitored to make sure people were protected as much

as possible from avoidable harm. However, we saw that the laundry detergent was kept in a cupboard that did not have a lock. Laundry detergent is a hazardous product and this meant that there was a risk that people could be harmed. We spoke with the senior staff member about this, who immediately ensured that all laundry detergent was placed in a lockable cupboard. Checks on the building and equipment in use, including fire safety checks and drills were being carried out. One person had been assessed as requiring a sensor mat to alert staff when they had a seizure. Tests to check that the equipment was working were carried out every week. This meant that the person could be assured the sensor mat would alert staff when needed.

There were policies and procedures for staff to follow in the event of a fire and each person had a personal emergency evacuation plan (PEEP). This was to ensure that staff knew each person's needs in the event of a fire or an emergency. These considered how each person might react during the day and at night if there was a fire and how to safely move people out of the building if required to do so. Plans were in place to enhance staffing levels at night when new people move into the home.

Infection control risks were managed safely and staff had completed infection control training. We saw that staff used personal protective equipment (PPE), such as gloves and aprons when required. The provider had an infection control policy, which detailed the relevant infection control issues and guidance for staff. During this inspection, we found the communal areas of the home, such as the living room, the kitchen, and people's bedrooms were clean and appropriately maintained. There were daily cleaning schedules and care staff were responsible for carrying out the cleaning duties within the home. Staff told us they used dispersible laundry bags to ensure infection control was maintained when they took laundry through the home to the washing machine.

The provider had an accident and incident reporting system. We reviewed incident and accident records for three people. The records showed a pattern had been identified and the senior staff member had taken action to seek support from external professionals. Assessments had been used to determine the potential triggers for incidents and to request additional support for the people.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in September 2015 we recommended that the provider sought advice and guidance on adopting the latest best practice guidance in respect of mental capacity assessments for people living with a cognitive impairment.

At this inspection, we found that this recommendation and the principles of The Mental Capacity Act 2005 were not being followed in line with legislation and guidance. 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's capacity to make decisions had been assessed. People were assessed to lack the capacity to make specific decisions, such as the support they received or the administration of their medicines. During the care planning process, staff had made these decisions on their behalf. However, records had not always been made to show how these decisions had been made and who had been consulted, as required by the MCA Code of Practice. Staff had not followed the MCA code of practice. Therefore, the provider was unable to demonstrate why the decisions they had been made were in people's best interests.

The failure to meet the requirements of the Mental Capacity Act 2005 by recording decisions made in the best interests of people, who lack capacity, is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At this inspection, we checked whether the service was working within the principles of the MCA, and whether DoLS applications had been made appropriately. We found the provider had made DoLS applications for people at Carter Avenue and these had all been authorised.

The families of people using the service told us they felt the service was effective and that staff understood their relatives' needs and had the skills to meet them. One family member said, "The staff know [person's name] very well and things have improved since the senior [staff member] has made changes and I feel [person's name] is more involved with things now." They also said, "[Person's name] can't verbally communicate but does make their choices known and are involved."

People's needs were not always met by the adaptation, design and decoration of premises. For example, one staff member and an external professional told us that they struggled to get people in and out of the home in wheelchairs, as the step to the front door was too high and difficult to get over. The provider had not identified this in their audit process. We discussed this with the provider who told us that they were not aware of these concerns and had not been informed by the registered manager. However, the provider assured us that they would review this and take action if required. People's rooms were decorated in

consultation with family and friends who knew them well and contained things that the person liked. The registered manager and provider carried out audits that identified any repairs or changes needed as part of the on-going maintenance within the home. One staff member told us that there were plans to adapt the garden in order make the accessible space for residents larger and we saw that the provider had identified this in their audit process. This process had also recognised that the kitchen ceiling had been damaged by water and had been scheduled to be repaired.

Staff were supported through the provider's mandatory training programme, which included safeguarding, fire safety, first aid, infection control and moving and handling training. The senior staff member for the service showed us the staff training spreadsheet that was in place. This identified the training that staff had completed and when further training was needed and was kept up to date. One staff member told us that they had a certificate in challenging behaviour and felt confident on how to use distraction techniques. However, not all staff had not been provided with training to support them to manage behaviour that challenges and one staff member told us, "I don't feel I am getting enough emotional support or training to be able to do my job well." Another staff member said they had only received training on challenging behaviour verbally and through advice from other staff; while another said, "I have asked about doing some training in challenging behaviour and further training in epilepsy and the senior staff member has agreed to look into this." This meant that although staff members had received training to meet the needs of people, they lacked confidence and were not trained to meet the changing behavioural needs of people at Carter Avenue. We discussed this with the provider's representative, who told us that the staff were currently being supported by external health professionals and behaviour support plans were in place. However, they would source additional training if required.

Staff had received an induction into their role and this provided them with information about the service and what their role would be. Staff told us that they had completed a number of shifts shadowing an experienced staff member, before they worked alone with people. We saw that staff had relevant qualifications such as National Vocational Qualifications (NVQ's) in health and care or The Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The senior staff member told us that new staff received the provider's induction and if they had not already achieved it, would undertake the Care Certificate. Staff we spoke with said they felt well supported and could ask the registered manager or senior for support.

Staff had regular supervisions and staff who had been at the service for longer than 12 months also received an annual appraisal. Supervision is dedicated time for staff to discuss their role with a senior member of staff. They were used to gain feedback on their performance, identify any concerns, and identify learning opportunities to help them develop. Staff said they felt supported by the registered manager and the senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us they felt able to speak to the senior staff member at any time and felt they were very supportive.

People were provided with suitable and nutritious food and drink. Staff told us they knew what food people liked and disliked and the menus were developed by staff with this in mind. Staff told us that there were plans to introduce a new system using pictures and symbols to enable clearer communication around food choice. People were unable to verbally communicate their food or drink choices; however; we saw choices being offered and people indicating what they wanted by making verbal sounds or touching. We refer further to people's choice and communication needs in the responsive section of this report.

People were supported to maintain good health and had access to appropriate healthcare services. Records showed they had regular appointments with health professionals, such as chiropodists, speech and language therapists, nurses and GPs. One person had recently required the intervention of a number of

external professionals and we saw that the management team had made requests for their support promptly. In addition, a senior staff member had contacted a specialist health organisation for advice about a person's vision and this had resulted in positive outcomes for the person's health and wellbeing.

Each person had robust information within their care plan to enable staff to understand their health needs and how to meet them. Essential information about their health and care needs was in an emergency pack and could be sent with the person, should they need to be transferred to another service or to hospital.

Technology was being used to alert staff to when people required assistance at night, such as sensor mats. However, technology was not used to enhance people's wellbeing. People did not have access to technology such as computer tablets or sensory equipment to enable improved communication and engagement with people and the environment.

Requires Improvement

Is the service caring?

Our findings

The atmosphere at the home was relaxed and friendly and staff appeared to know people well. We were unable to communicate verbally with the people at Carter Avenue but observed people looking relaxed and content throughout the inspection. Family members told us they thought that the staff were caring. One family member said, "[Person's name] keyworker is absolutely marvellous and has formed a great relationship with [person's name]." One staff member was observed saying, "Hi [person's name] I've got your medicine; is it ok if I give it to you now?" While another said, "Well done [person's name], you did really well."

Care plans and confidential documents were kept securely in the office and only staff could access these. We saw staff respecting people's privacy and dignity by knocking on doors before entering rooms. Staff told us how they would respect someone's privacy. One told us, "I close the door, and explain what I'm doing so the person understands." Another staff member described how they supported one person when they had a bath. They explained how the person liked having a soak in the bath and put on their favourite music so they were relaxed. However, when we asked one staff member how they would respect someone's privacy whilst they were in the bath, they replied, "Well, they are under the bubbles, that's enough". We also saw that one person was wearing an apron all day and this was wet and looked tatty and old, while another had a wet patch on their jumper and this was not changed. This demonstrated that not all staff recognised the importance of maintaining privacy and dignity when supporting people.

We observed staff speaking with patience and kindness, sitting with people and chatting to them and supporting people with activities. A senior staff member spoke to us about each person and knew what their support and care needs were, what they liked and what was going on in their life. However, we also heard staff referring to people as a "good girl," and observed a member of staff patting a seat, calling to a person so they would sit down, and speaking in a childlike way. Whilst the use of this language and tone may not have been intended to cause people upset, it could result in people feeling they were not respected or valued and was not in line with best practice.

Most people using the service were unable to fully verbally communicate due to their learning disability and required a high level of support to be able to engage in activities and tasks of daily living. We saw details of how each person should be supported to participate in daily life recorded in their care plans. At lunchtime, we saw staff supporting one person to help make their lunch. The staff member gave lots of encouragement to support the person to be involved. This showed that staff worked with people to engage them in what was happening in their home. Although we were told that there were plans to introduce accessible communication tools, such as pictures or symbols to assist people to understand information and to make choices, these were not actively being used at the time of the inspection.

Staff told us they enjoyed working at the home and one said, "I like to interact with the residents, there is no rushing around and all of the staff are really nice." Another said, "I love it here, it's like home from home, and the residents are like my family, it's their home and they are very happy here." An external healthcare professional told us, "One staff member I have been working with is caring and appears passionate about getting the right support for the residents at Carter Avenue."

Staff supported people at their own pace and at the times that people wanted or needed support. People's daily needs were met and they engaged in activities within the home. We heard another member of staff talking to a person about what they wanted to watch on television. They said, "Oh [person's name], do you want to watch that DVD again? I'll show you what other ones we have." The person then pointed to the DVD they wanted and the staff member said, "Ok, we will put this one on for you." This demonstrated good consideration for the person's choice and involved them, offering options and recognising the things that the person liked. Another member of staff was supporting a person to play an interactive game. The person successfully completed a task and the staff member said, "Well done, that was great, you knocked 4 over."

One person liked to attend church and had a friend who visited and took them to church regularly. Although no one else's cultural, religious or personal beliefs were identified in their care plans, we were told that public holidays and birthdays were celebrated with traditional foods and activities for people to participate in if they wished to.

Family and friends were free to visit whenever they wanted to and one family member told us, "I can go and see [person's name], whenever I want to and we do visit quite often." They added, "I can ring up if I want to know something and find the staff very good."

The home had engaged the service of independent advocates for some people. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. We were told that advocates had liaised with the staff and other professionals that knew the person well, so that decisions could be made on their behalf. At the time of the inspection there were plans for some new people to move into Carter Avenue. Advocates had been used to support the people to decide if they would agree to new people moving in to the home.

Requires Improvement

Is the service responsive?

Our findings

The family of a person using the service and an external professional told us they felt the service was responsive to people's needs. One family member said, "They know how to support [person's name], they can make their choices known." An external professional told us, 'The staff team at Carter Avenue have shown themselves to be responsive to the needs of the person I am working with.'

Initial assessments of people's needs had been completed when people moved into the home and care plans were developed which met their needs. As part of the initial assessment process, relatives were involved to ensure staff had an insight into people's personal history, their individual preferences and interests. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels. Copies of care plans were accessible to care staff should they need to refer to these. Care plans were focused on the person and included their preferences, communication and support needs. They also contained up to date guidance for staff about how each person liked to be supported when taking their medicines, receiving personal care or when eating and drinking. This meant that staff could find the information they needed about the person's health needs, what they liked and how they needed to be supported. For example, a staff member was able to explain to us how one person enjoyed particular activities and the reasons for this. We saw the person being supported to participate in these activities during the inspection, which demonstrated that staff were following the care plans. However, people's care plans were not accessible to them and staff did not use communication tools or photo's to aid understanding and involvement of the person.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. We discussed this with the provider's representative and a senior staff member. They were aware of this standard and that that they needed to develop information in a way people could understand. We were told that communication tools that were being developed to support people to understand and be more involved in their care planning. A senior staff member said that each person's care plan would be developed to contain pictures and symbols, specific to each person so that their care plans were accessible to them.

Care plans should be reviewed regularly and involve the person, their family or an advocate. One family member told us, "We are kept informed and involved with things; the staff are good at involving us." However, we saw that reviews of care plans and risk assessments had recently been updated to reflect changes, but these had been carried out by staff members and had not involved people or their families. We discussed this with a senior staff member, who told us that families had not been regularly invited in for reviews of people's care, but advocates were involved with people and reviews with family members were now being arranged.

Staff members made records of the care and support people had each day. However, on the first day of the inspection there was an incident involving two people. We later saw that this incident had not been recorded in the daily record of the people involved. This meant that important information about people's

needs may not be accurately handed over to staff and therefore the care and support of the person may not be adapted to meet their specific needs each day. This was discussed with a senior member of staff who said that staff would be reminded of the importance of maintaining accurate records. Handover meetings were held at the start of every shift and supported by a communication book, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting.

Person centred care is considered best practice and is a requirement of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providing support in this way meets each person's individual needs and enables them to maintain or develop new skills where possible. Each person had a keyworker. Keyworkers are members of staff whose role was to be the focal point for that person and maintain contact with the people that were important to them. Staff knew the people well and they were able to tell us about their preferences, backgrounds, medical conditions and behaviours. One staff member told us, "People's care is based on them as an individual."

We saw some person centred care being delivered; for example, staff members offered people choices by showing them objects so they could touch the one they wanted. We were also shown plans to further improve communication and choice for people. One example was the use of a 'twist and turn' care plan. This was a laminated plan using pictures and symbols and would have specific information about the person's needs, likes and dislikes. A 'twist and turn' plan arrived on the second day of the inspection and we were told that these would be hanging in people's own bedrooms. People would be supported to fill them in and look at them each day to see anything that was planned for that day or to help make choices about what they wanted to do. Although this demonstrated that the home had identified ways in which to improve the engagement of people in their own care and to offer increased choice and involvement, this was not being used at the time of the inspection.

Staff were patient when speaking with people and understood and respected that some people needed more time to respond. Although people were not able to verbally communicate with staff, they were, at times, able to demonstrate their understanding and make their wishes known. Staff were responsive to people's communication styles; however, this was often due to staff familiarity. One staff member said, "We try to help them be as independent as they can; we make it feel like a home, we enable them to do as much as they want". We observed staff verbally offering choices to people and showing them items so they could indicate what they wanted. Staff told us that people were involved in their own lives and they tried to give people choice as much as possible. One person's daily care record showed that the person was being supported to carry out daily tasks with staff support. For example we saw records that said. " [Person's name], has helped to make their bed today", and another that said, "[Person's name], has helped to lay the table for breakfast this morning."

We saw that staff spent time with people doing activities in the home. The home had also engaged an activities person to provide 'chair exercises' once a week. The activities person was there on the first day of the inspection and people responded positively to this and appeared to enjoy the activity. One family member said, "Things have improved a bit recently; one staff member is very good and they are now doing more with [person's name]." The home had games for people to play which we were told they enjoyed. However, some of these games and activities were designed for children. Care plans did not evidence an assessment of each person's choices around games and activities, to demonstrate if they would have more positive experiences with sensory activities designed for people with learning difficulties or Autism.

People were not going out into the community regularly. We discussed this with a senior staff member who told us that it had been difficult to access the community when it was colder. People at the home did not enjoy going out when it was cold and we were told that they indicated this to staff in their behaviour when

staff tried to support activities outside. In addition, a family member told us, "It has been difficult for the staff to get [person's name] out as they developed a fear of going in the car following an incident. However, things have got better and recently they managed to get them out for something to eat and this went really well." One family member told us, "[Person's name], used to go to a day resource centre where they had a sensory room, they really loved that and responded so well to it." The provider had not carried out effective audits or reviews of people's meaningful engagement in activities. This information could be used to increase understanding of people's needs and enable staff to adapt their support accordingly.

The provider had a complaints procedure and this was available to people in an easy read format. However, not all the people who live at the home understood the easy read version due to their learning difficulties. The provider's representative told us that the home had not received any complaints in the last year. A family member said, "I've not had to complain about anything, they [staff] are all very good." We were told that if any complaints were received, they would be managed and recorded through the system that the provider had set up. We discussed the possibility of low-level concerns being raised by people or their families that could be used to develop the service and learn from past experiences. This information was not being captured and therefore the provider was unable to monitor themes or patterns. We asked staff how they would know if a person was unhappy or wanted to complain. One staff member said, "It would be difficult not to lead residents into saying something, or put an idea in their head, I don't know the answer. We discussed this with a senior staff member, who told us that the home were going to start using pictures and symbols to enable people to express any concerns or complaints they may have.

Some staff had received end of life training to assist them to support people at the end of their life and to make plans for any arrangements they would want. However, people's care plans did not contain information about any end of life care or the person's wishes. We saw that one person's care file had a record that stated that the next of kin should be contacted to make any funeral arrangements.

Requires Improvement

Is the service well-led?

Our findings

Family members told us that they felt the home was well-led and that they had "no concerns." They added, "We can ask if we want to know anything and feel we are listened to."

Quality assurance processes were not robust. The provider had quality assurance processes to identify environmental risks, risks to people and to consider staff responsibilities and training. For example, audits had not identified the lack of best interest decisions recorded in people's care plans and this had led to a breach of regulation. Audits had also not identified that staff had not always received the training they needed to carry out their role safely and this put staff at risk of harm. The home also had internal audit processes such as for medicines. However, a medicines error picked up by an audit, had not been resolved to ensure that the medication was administered and the MAR signed. This meant that the management team could not be assured that the person received their medicine. The quality assurance systems used were ineffective in assessing where the service required improvement.

There was a registered manager in place who was responsible for the day-to-day running of the service. The registered manager was also employed as the registered manager of another home, owned by the provider. This meant that their time was divided between the two homes and therefore impacted on their ability to ensure that the service was well run. The registered manager worked 18.5 hours at this home and another senior member of staff complimented the management cover by a further 7.5 hours a week. The amount of hours the registered manager was employed at the service meant that they had less protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. The provider had failed to provide sufficient time, structured support and oversight to enable the registered manager to undertake their role effectively and to a good standard. However, at the time of the inspection, the registered manager was unavailable and a senior member of staff was temporarily working 37 hours each week to cover the management role within the home.

An interim group manager started working with the service towards the end of 2017. However, they were not directly responsible for undertaking the responsibilities associated with the registered manager role. During the course of the inspection each time we informed the senior staff member or interim group manager of our findings of an area that required improvement, they were responsive and demonstrated that work was being undertaken to address concerns and change practice to improve outcomes for people living in the service. For example, we saw communication tools that had been purchased so that improvements could be made to involve people in their care planning. In addition, when we returned on the second day of the inspection, action had been taken by the provider to address staffing issues as detailed in the safe section of this report. This demonstrated that the provider and senior staff member were reactive when shortfalls were identified but had not proactively identified all shortfalls through their own quality monitoring systems.

Systems to monitor the quality and accuracy of peoples' care records had recently been updated and risk assessments for people were up to date. The senior staff member told us that the staff team were introducing the use of pictures and symbols to improve people's ability to communicate their choices. However, these were not yet implemented into the support people received and we did not see examples of

this in use. Though we did see that a recent "residents meeting" had taken place and this had been carried out using photographs so that people could make choices. The senior staff member told us that this had worked well and people had responded to the choices offered. As a result, they had agreed to a coffee and cake morning, where relatives, friends and people involved in their lives would be invited into the home. We were assured that the further introduction and use of accessible information would be embedded into practice in the near future.

Staff felt supported by the registered manager and one staff member told us that when they had raised concerns about the number of staff available to carry out their role, the senior staff and registered manager had listened and raised these concerns with the provider. The senior staff member explained to us that there had been some recent challenges around staff availability and this had an impact on the running of the service. They told us that they used staff from the provider's other homes to help support the staffing when needed. However, staff shortages had meant it has been more challenging to implement the planned improvements for a more person centred way of working and the use of improved communication tools.

Staff meetings had not always been held regularly. However, action had been taken to address this and staff meetings had been held for the two months prior to the inspection and were booked monthly over the next year. Staff meetings provided the registered manager with the opportunity to update staff on any changes in policies, remind staff of their responsibilities and discuss any concerns about care provision. These meetings also provided staff with the opportunity to share ideas with the registered manager and talk about any concerns they may have.

The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. The staff were aware of the different external organisations they could contact if they felt their concerns would not be listened to.

The senior staff member told us that they had regularly liaised with external professionals to work together to meet changing needs of people. We saw records for one person that showed how their changing needs had been identified and that prompt action had been taken to engage with health and social care professionals. In addition, they also told us that they had engaged with national charities to get advice and support to look at different ways of working and the use of technology or adaptions to the home. For example, advice had been given that suggested that walls and doors should be painted in contrasting colours to assist a person's vision. Although this work had not yet been planned, other advice given such as the use of daylight bulbs, had been resolved immediately.

The provider's representative told us that recent links had been made with another provider whose service has been rated as outstanding. This was so that positive ways of working could be shared and training provided for the registered manager and staff. In addition, they told us that they had identified further training needs for the staff team and ways in which to develop a more person centred approach for the people at Carter Avenue. However, these changes had not yet been implemented and we observed some language being used that was not in line with best practice. Further information about this can be found in the caring section of this report.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. These had been used to identify themes and trends and had recognised the changing needs of one person.

People, their families and staff were not actively involved in developing the service. Reviews of care plans were carried out monthly by staff that checked through people's care files. However, we saw no evidence that this involved the person. Although one family member told us they felt involved, families had not been

invited into a review for some time. The views of people and their families had not been sought, therefore, the registered manager was unable to monitor or evaluate their views in order to develop and adapt the service.

All services registered with the CQC must notify the CQC about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service had notified CQC about all incidents and events required.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in September 2015, was prominently displayed at the home and there was a link to the CQC's rating on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to meet the requirements of the Mental Capacity Act 2005 by recording decisions made in the best interests of people, who lack capacity