Parkcare Homes (No.2) Limited

Mather Fold House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection at Mather Fold House on 09, and 11 July 2018.

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

Mather Fold House is a six-bed residential service in Higher Walton, Lancashire. This specialist autism service is for male and female adults aged 18 years and over but can also accommodate people who are 17 years and are going through transition from children to adult services. At the time of the inspection, there were four people accommodated in the home.

The care service is aware of the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. However, we found on this inspection that the service was failing to deliver these values.

There was a registered manager at the time of our inspection. However, they were not present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection carried out on 06 and 07 July 2017, we asked the provider to make improvements to arrangements for protecting people against improper treatment. This was because people were not protected against the inappropriate use of physical restraint. Following the inspection, the provider sent us an action plan and told us they would make the necessary improvements by November 2017.

During this inspection, we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found continuing shortfalls in the safeguarding of people against abuse and improper treatment. In addition, we identified further shortfalls in the way risks to people's health, safety and welfare were managed, medicines management, infection control practices, staff training and development, procedures for treating people with dignity and the governance arrangements.

At the last inspection, the service was rated as overall 'requires improvement', at this inspection the rating had deteriorated to overall 'inadequate'.

We are considering what action we will take in relation to these breaches. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

We received mixed feedback from relatives regarding the safety of their family members. One relative felt the care was unsafe and some felt the care provided was safe but needed improvements.

Safeguarding adults' procedures were in place and staff spoken with understood how to safeguard people from abuse. However, we found two instances where staff had failed to recognise serious incidents as safeguarding concerns and delayed completing an incident report and reporting to the authorities. Whilst there was evidence to indicate the circumstances of one of the incidents had been investigated there was no evidence seen to confirm the incident had been reported under safeguarding adults' procedures.

We saw people's care files contained individual risk assessments, however, not all risks had been assessed and recorded and consistent action had not always been taken to mitigate risks. One person had no care plan to guide staff. Staff did not always follow risk management plans such as allergies and did not wear protective clothing.

People were not adequately protected from improper treatment and abuse from staff and disciplinary policies were not adequately followed.

We found measures for protecting people against the risk of infection were not robust and there were shortfalls in the management of medicines. Improvements were required to the maintenance of the premises.

We found significant shortfalls in the training that staff were required to complete as part of their role. A significant number of staff had not completed induction training when they commenced work in the home. Furthermore, not all staff had received supervisions as directed by the provider's policies and procedures.

The arrangements for monitoring and assessing quality in the home to ensure people's safety and compliance with regulations were inadequate. There were various audit tools to assess the quality of care

which identified shortfalls. However, the shortfalls were not addressed in a timely manner and internal audit and quality assurance systems had not been effectively implemented to assess and improve the quality of the service. There was a lack of robust governance and leadership. Managerial oversight of staff and the care that people received was inadequate.

Two relatives told us the staff were caring and kind. However, some of the practices in the home demonstrated people had not always been treated with dignity and respect.

Each person had an individual care plan, however, we noted one person did not have a complete care plan also known as a behaviour support plan. Relatives were not involved in the planning or review of care plans.

Relatives informed us communication in the home was not effective and some did not feel they were listened to or that actions were taken if they raise a concern.

The provider was working within the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected.

People had access to healthcare services, and staff had responded in a timely way to seek medical advice. Staff had been safely recruited.

There was a complaints procedure in place and we saw evidence complaints had been investigated and responded to. Relatives did not always know who to approach if they had a complaint.

There were adequate number of staff to meet people's needs. There was an end of life policy however staff had received training in this area.

People were supported to undertake activities of their choice in the community on a regular basis. We saw one person had thrived and made progress from our last inspection.

The provider and their relatives responded positively to the shortfalls and took immediate action to take corrective action.

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's relatives had mixed views whether people were safe in the home. Some felt the service was not safe.

People were exposed to risks of abuse and improper treatment. People's medicines were not always managed in accordance with safe procedures.

Improvements were required to the management of the risks in relation to care and infection control measures.

There were adequate staff to look after people during the inspection. Staff were safely recruited however, disciplinary procedures in the home were not transparent and effectively implemented.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Staff did not always receive relevant training, induction and supervision.

People's health needs were met. Specialist professionals were involved when risks increased.

The environment required improvements to ensure it met the needs of people in the home.

The rights of people who did not have capacity to consent to their care were supported. Mental capacity assessments were carried out.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Some relatives raised concerns about the caring ethos in the

home. However, some were happy with the care provided.

People's personal information was not managed in a way that protected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people had complete care plans and reviews were not robust because relatives were not involved in planning and reviewing care.

People were provided with a variety of activities however, improvements were required.

End of life care planning had not been established.

There was a complaints policy which had been followed.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems and processes in place to monitor and improve the service or assess, monitor and mitigate risk. Leadership arrangements were unstable.

Audits had been undertaken however concerns were not rectified in a timely manner.

There was a lack of oversight on the running of the service. The provider and the registered manager had not adequately supported staff to deliver safe care.

Mather Fold 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

An unannounced comprehensive inspection took place at Mather Fold House on 09 and 11 July 2018. The inspection was carried out by one inspector, and an assistant inspector.

In preparation for our visit, we considered the previous inspection report and information that had been sent to us by the local authority's contract monitoring team. We also checked the information we held about the service and the provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

Prior to the inspection, we received a significant number of concerns about the operation of the service from staff and local safeguarding professionals. Whilst some concerns were being investigated by the local authority's safeguarding team, we analysed the information and incorporated the themes into the planning of this inspection.

As this inspection was in response to concerns we had not asked the provider to submit a Provider Information Return. This is information we ask providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit, we spent time observing how staff provided support for people to help us better understand their experiences of the care they received.

We spoke with three relatives, five members of staff, the administrator, two quality improvement leads, the chef, the deputy manager, the operations director and the interim manager. We also spoke with a visiting healthcare professional and a social care professional.

We walked around the building to check it was clean and safe environment for people living there. We also looked at a range of documents and written records including a detailed examination of three people's care files, three staff recruitment files and staff training records. We also looked at a sample of people's medicines administration records, the policies and procedures, complaints records, accident and incident documentation, meeting minutes and records relating to the auditing and monitoring of service provision. Following the inspection, we asked for the records relating to complaints made about the service and records were submitted to us.

Inadequate

Is the service safe?

Our findings

At the inspection in July 2017, we were concerned because arrangements for ensuring people were protected from abuse and improper treatment were not robust. We found people were not protected from the inappropriate use of physical restraint. Following the visit, the provider sent us an action plan to tell us how they would make improvements to the service. At this inspection, we found some improvements had been made to the system used to monitor the use of physical restraint, however we found new concerns in that people had experienced inappropriate treatment. This meant the provider was still in breach of the regulation. There were also shortfalls in the practices for preventing the spread of infections. We also identified additional shortfalls in the way people's medicines were managed and the management of risks to receiving care.

At our last inspection, we found the provider had failed to safeguard people against the risk of abuse and improper treatment. This was because there was inappropriate and disproportionate use of physical restraint by staff. Following the inspection in July 2017, the provider sent us an action plan telling us what they intended to do to ensure they were compliant with the regulations. We found some improvements had been made. There had been a reduction in the use of physical restraint and systems had been put in place to monitor whether staff were using restraint proportionately. However, we found there were instances when staff who were not trained in physical restraint procedures had been involved in restraint interventions. This increases the risk of injury to people and staff involved. We also found de-briefs were not consistently undertaken following incidents and interventions. De-briefs are meetings held by staff who have been involved in an incident or intervention to discuss what had gone well or wrong with their intervention and what can be improved next time. In addition, records of people's behaviour were not adequately completed to facilitate learning and understand trends and devise ways to prevent behaviours that could result in the future use of restraint. This meant that the provider had failed to ensure compliance with the regulation.

We looked at how people were protected from abuse, neglect and discrimination. There was a safeguarding adults' and whistle blowing policy and procedure in place and information was displayed in the reception. The information we received before the inspection showed staff knew how to report concerns and were confident to do so. Some of the staff spoken with during the inspection understood their role in safeguarding people from harm and told us they had completed relevant training. They said they would report any incidents of abuse to the management team and were aware they could take concerns to organisations outside the service if they felt their concerns were not being dealt with.

However, on looking at the incident records we found some staff had not always put their learning into practice. We found instances where people had been treated inappropriately by staff. For example, we found an instance where a staff member had been reported to have forced a person to have a shower against their will. We looked at the investigations undertaken by the registered manager and found these were not robust and had not followed the organisation's own policies. In another case, staff had failed to complete an incident form at the time of a serious incident at the home. According to the records seen, an incident had happened, and a staff member had been found to have been shouting and swearing in the

presence of people. As a result, the staff member was asked to apologise to people. There was no evidence the circumstances of the incident had been reported to the local authority under safeguarding adults' procedures.

We found incidents where one staff had acted in an inappropriate manner which compromised a person's dignity. Daily records we saw showed that a staff member had deliberately altered a person's daily routine resulting in a person having to go to bed early before they completed their preferred routine. This caused an upset with the person involved. Records we reviewed showed the staff member had recorded that because of the alteration to the person's routine, the person had gone to bed in a 'sulk'. People who live with a learning disability and autism follow specific routines as part of their daily living activities and any unplanned alterations can result in distress or disruptions to their way of life. This behaviour from this staff member demonstrated that people's preferences and routines were not followed, and people could not be assured they would be treated with dignity.

In another example, a staff member was observed to have put a person in a headlock which is an inappropriate form of restraint. This incident and all incidents above were reported to the safeguarding team and the police and were under investigation at the time of our inspection.

Following the inspection, we met with the representatives of the provider. We asked them to confirm the incident had been appropriately dealt with. We also asked them to review their procedures for internal safeguarding investigations. They informed us that the organisations' policies had not been followed and that they would be reviewing the safeguarding processes immediately to ensure all investigations were over seen by senior management. In addition, they informed us they had taken disciplinary action against all staff involved and they no longer worked at the service.

There was a failure to operate an effective procedure to safeguard people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at how risks to people were assessed and how their safety was monitored and managed so that they were supported to stay safe. We saw that staff had carried out a number of assessments for each person to identify risks to their health and safety in relation to their care needs. For example, some people had risks in relation to behaviours that could expose them and those around them to harm. Others had risks associated with maintaining their own safety in the community and during activities. However, we found not all these risk assessments had been completed in sufficient detail to ensure they were centred around the needs of each person.

Relatives had shared information around people's known risks with staff. However, the information was not always followed or incorporated in risk management plans. For example, a relative had shared information on food items that one person was intolerant to, however staff continued to provide the person with these types of foods. This had an impact on the person's behavioural needs. We also noted there were people who were at risk of ingesting foreign objects however, we observed various objects had been left around the home including cleaning materials. This would increase the risk of people ingesting objects and choking. We shared this with the interim manager who informed us this would be dealt with immediately.

Three of the care records we reviewed showed that each person had a behaviour support plan which provided staff with detailed guidance to staff on how people were likely to present and what strategies staff would consider to maintain people's safety. However, we found one person had no written support plan. Although they had some risk assessments, they did not have behaviour support plans which are essential in

providing staff with specific guidance on how to safely support the person. This was essential in a service where there was a significant use of agency care staff who were often not familiar with people and where people's presentation could be changeable.

There were written protocols which required staff to review people's behaviour and incidents that had happened in the home. The system required staff carry out practice workshops. This is a practice where staff formally review and reflect on incidents to identify what had gone well and what needed to be improved to reduce risks to people. Our findings revealed that the system was not effectively implemented due to the lack of information recorded on incidents and people's presentation. We found conclusions in the practice workshops were consistently pointing out that 'an accurate analysis of people's risks and behaviours could not be completed due to the lack of information recorded and the poor quality of the information'. This lack of accurate analysis meant that staff and the organisation could not demonstrate how they were learning from incidents in the service.

We found staff did not always follow risk assessments and care plans to ensure the safety of people to protect themselves from harm. During the inspection, we observed staff were not wearing protective clothing which had been recommended for staff who worked with certain people in the service. For example, staff were required to wear shin guards and bite proof sleeves however we noted one staff member wearing a sleeveless shirt and others not wearing the protective clothing on both days of our inspection. This meant staff were failing to follow measures that had been agreed to protect them from injury. We raised concerns with the managers at the service during and after the inspection and they assured us that all staff will be reminded to wear protective clothing where required.

There was a failure to protect people from risks to receiving care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives raised concerns about people's safety in the home. One relative said; "I think it's the worst place for incidents. There is just too many incidents and I'm worried about [family member]". Another said, "The environmental risks needs to be managed better, they need to make sure things are not left lying around the home and soiled clothes are left lying around. Objects that people can swallow are left lying around."

We looked at the cleanliness of the home. There was an infection control policy, cleaning schedules and personal protective clothing had been provided. However, some parts of the home were unclean and cluttered. For example, in one of the annexes we found cleaning chemicals stored on the staircase together with other items such as continence pads and a plate of food which was not covered. This was a trip hazard for staff who used the stairs to access the medicines room and posed a risk of cross contamination. We also noted in the main house bags of clinical waste and soiled clothing had been left in one of the communal showers all day. This increased the risk of spread of infections. We shared these concerns with the interim manager and asked them to take corrective action. They also informed us that an infection control audit visit had been arranged with the local authority.

There was a failure to protect people from risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider ensured the proper and safe use of medicines in the home. We found policies and procedures for the safe management of medicines had not always been followed to ensure people received their medicines safely.

We checked the arrangements in place for the management and storage of controlled drugs which are

medicines which may be at risk of misuse. We found appropriate secure storage was provided. There were appropriate security arrangements to monitor the medicines cupboard. External support had been sought to support the safe management of medicines and some staff had received medicines training and competence checks. However, the room temperatures where the medicines were kept were not being monitored. For example, we found in one month temperature had not been recorded for 19 days and in another for 16 days. We looked in one person's medicines storage areas and found on the day of the inspection the temperature was 28°C. The recommended temperature is 25°C. We could not be assured that staff had monitored the temperature to ensure that medicines were not compromised. The manager took immediate action to install cooling fans in the medicines rooms. However, on the second day of the inspection we noted that temperatures were still not recorded consistently.

Before the inspection we had received concerns on how people were supported with their medicines. There had been reports of medicines errors. The provider had assured us that staff had received competence checks and re-training following medicines errors. We checked to see whether the support had been provided. However, we found one staff member had made two errors within three months. We found no training or competence checks had been undertaken regardless of the undertaking provided by the registered manager and the provider that they had been re-trained. This meant that staff did not always receive support to improve their competences following medicines errors, which increased the risk of errors re-occurring. Following the inspection, we were informed that all staff will undertake medicines management training.

Medicines audits were carried out regularly however, they had not identified the shortfalls we found. This meant that the medicines audits were not effective. This may expose people to risks of medicines mismanagement.

There were shortfalls in the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted arrangements were in place if an emergency evacuation of the home was needed. People had personal emergency evacuation plans (PEEPs) which recorded information about their mobility and responsiveness in the event of a fire alarm. We saw there was a business continuity plan in place to respond to any emergencies that might arise during the daily operation of the home. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power or severe weather.

We checked the arrangements in place for the maintenance of the premises. We saw records to demonstrate regular checks were carried out on the fire systems, water temperatures, and gas equipment. The electrical and gas safety certificates were in date and we noted appropriate arrangements were in place for servicing the fire systems including the fire extinguishers. We noted some areas of the home had signs of rising damp, we shared our observations with the manager who informed us that they thought this had been resolved and that they would get this rectified.
Before this inspection we had received concerns from staff regarding staff shortages. We contacted the provider and asked them to provide us with records of their weekly duty rosters. The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. There was a high usage of agency care staff to provide cover due to high staff turnover. However, during our inspection visit, staffing levels were observed to be sufficient to meet the needs of people who lived at the home. The manager informed us they were recruiting more staff.

We looked at staff recruitment processes. We reviewed the recruitment records of three staff members and found that safe recruitment procedures had been followed. We saw the required reference and character

checks had been completed before staff worked at the service and these were recorded. Disclosure and Barring Service (DBS) checks had been carried out before staff started their employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2017, we found shortfalls in relation to staff training, supervision and induction. The provider had failed to ensure that staff had completed training in areas that they had deemed necessary for the role. We also found shortfalls in the way training records were kept. As a result, we made a recommendation that the registered manager and the provider considered recognised best practice in the delivery of staff training and development. At this inspection we found the recommendation had not been followed.

Before this inspection in July 2018, we had received concerns that staff were supporting people without the necessary training for example training in relation to the use of physical restraint. During this inspection we checked to see what improvements the provider had made in relation to staff training induction and supervision. We found staff had been offered online training in various areas of their roles. These were introductory courses including food safety, safeguarding, basic life support and safe handling of medicines. Staff had completed these online training courses in the majority of cases with shortfalls in some areas. However, in addition to the online training the provider's policies required staff to attend face to face training and to complete an induction programme and the care certificate. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. Induction training is important to enable new staff to learn about the values and culture of the organisation as well as what is expected of their role.

The training records for face to face training showed staff who worked at the service had not completed the training that the provider had deemed mandatory for the staff working in the service. For example, 19 out of 22 care staff had not received training or induction related to the care of people living with a learning disability or autism. This was concerning as the service was registered to support people who lived with a learning disabilities and autism. We spoke to the interim manager who informed us this training had been offered to the service by the provider however the previous managers at the service were reluctant to accept the training or to offer the training to staff. This lack of training and induction meant that people could not be assured they would receive effective care from staff who were knowledgeable and understood their conditions. In addition to this we found additional mandatory face to face training had not been provided including training in relation to food hygiene, safeguarding training, mental capacity, infection control and dignity in care. Food hygiene and infection control training was essential in this service because staff were involved in supporting people with their meals and personal hygiene. We spoke to the interim manager and the operations director who informed us that the provider had planned for staff to attend training however, the registered manager had cancelled training.

We also noted that training provided to staff was not always relevant to address identified learning or developmental needs. For example, two staff members, were involved in incidents where their actions lacked dignity and respect towards people. However, we found following disciplinary procedures staff members were recommended to attend training related to physical restraint. This training was not relevant to the area of development identified. This meant that the provider had failed to provide staff with suitable training to address training and developmental needs.

We found some staff had received supervision however this was not consistent. One staff member had not received supervision since December 2017, another had not received supervision since February 2018. Supervisions were meant to be provided every 3 months. The lack of supervision meant that staff were not adequately supported to ensure they can undertake their role effectively.

Following the inspection, the provider informed us that they were arranging training and induction for all staff. They assured us that this would be prioritised and would be completed immediately.

There was a failure to ensure that all staff had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about the effectiveness of the service. Comments from relatives included, "I am very worried about their ability to listen and share important details that we give them", "Some staff are very good, but it depends who you get on the day." And, "They don't seem to train them, there is a lack of training and a lack of common sense in some of them."

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 or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was working within the principles of MCA. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff told us they understood the importance of gaining consent from people. Where people had some difficult expressing their wishes they were supported by their relatives or an authorised person. Some consent records had been completed in relation to medicines management and health observations. When we undertook our inspection visit, all four people who lived at the home had DoLS authorisation requests submitted to the local authority and some had been authorised. All people had mental capacity assessments in their records with best interests support where they could not make their own decisions. Relevant professionals had been involved in deciding best interests' options for people.

We looked at how people were supported to maintain their health. We found all people were registered with a GP and had access to other healthcare professionals such as learning disabilities nurses and speech and language therapists. We spoke with two visiting health and social care professionals during the inspection, and they told us they had concerns about people's care as a result of a lack of training and supervision.

We looked at how people were protected from poor nutrition and supported with eating and drinking. There was a variety of choice for people. People's preferences with regard to food, along with any allergies or professional guidance were recorded and shared with the catering staff. This helped to ensure people received nutrition that met their needs and reflected their likes and dislikes. We noted nutrition and hydration assessments for one person who was at risk of weight loss and poor dietary intake needed to be improved to ensure there was adequate monitoring. We shared this with the interim manager who informed us they would review the care plan.

We noted that technology was used to support people living in the home. Staff had walkie talkies to assist them with communication across the home. However, there was no working Wi-Fi available to enable people to use the internet on their own devices.

People's needs, and choices were assessed to ensure that care, treatment and support was delivered in line with current legislation and best practice. The care service is aware of the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. However, we found on this inspection that the service was failing to deliver these values as they were not incorporating the values in their daily care practices

We noted that three of the people who lived in the home had comprehensive assessments which included transition assessments before they moved in. There were also specialist behavioural assessments and support plans undertaken in collaboration with specialist professionals such as psychologist. Before a person moved into the home, a representative from the management team undertook a pre- admission assessment to ensure their needs could be met and that they would be compatible to live with other people in the home. We looked at completed pre-admission assessments and noted they covered all aspects of people's needs.

We looked at how people's needs were met by the design and decoration of the home. Although areas of the building were decorated to a good standard, the environment had not been kept in good repair. We found areas where rising damp was evident and had not been rectified. Relatives informed us repair jobs had not been completed in a timely manner. Furniture and decorations were secure to ensure they meet the safety needs of people who lived in the home. There were secure garden areas which gave people the privacy they required if they wished to venture outside.

Requires Improvement

Is the service caring?

Our findings

We looked at how the service ensured that people were treated with kindness, respect and compassion, and whether they were given emotional support when needed. There was a policy on treating people with dignity and some of the staff had completed online training related to dignity and respect as well as equality and diversity.

During the inspection we observed staff caring for people in a sensitive and compassionate approach. We observed the majority of staff ensured personal care interventions were carried out behind closed doors in the person's bedroom or bathroom. However, before the inspection we had received concerns that people were not always treated with respect. For example, one person had been locked in their bedroom by a member of the care staff team. This resulted in the door being forcibly removed as staff were unable to unlock the door. This had a potential of causing unnecessary emotional upset to the person involved. We found another example where one person was hit by a ball which had been kicked by a staff member and an incident where a staff member used excessive force to restrain a person. These examples showed that people were not always treated with compassion.

We looked at care records written about people by the care staff, we found in majority of the cases the records were written well. However, we noted, in two care files we checked daily records had been written in manner which did not show respect or compassion. We found this had been identified four months earlier during the provider's own internal checks. Action had not been taken by the provider and the manager to address this with staff involved, which meant that the poor practice continued. In addition, we found the daily records were of poor quality with some loose pieces of paper stapled together and with some dropping off.

Staff we spoke with had a good understanding of protecting and respecting people's human rights. Some staff had received training which included guidance in equality and diversity. We discussed this with staff, they described the importance of promoting each individual's uniqueness. However, evidence we found showed that some of the staff had failed to act in a manner that showed their awareness of equality, diversity and human rights. Their approach was not consistent with the practice required to maintain people's rights under the Human Rights Act 1998. This meant that people's human rights were not always observed and protected at Mather Fold House. Following the inspection, we met with the provider's representatives and they assured us that all staff involved had been removed from the home and that all other staff would be offered training in record keeping and dignity and respect.

There was a failure to ensure that people using the service were treated with respect and dignity at all times while they are receiving care and treatment. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives spoken with had mixed comments about the approach taken by staff. Comments included, "The staff are very nice", "Some of them have developed really good relationships with [relative], they love [relative] to bits.", "The staff are all different it all depends on who you get." However, relatives also

commented about the consistency of care. For instance, one relative said, "I am so concerned about why staff are leaving" and another relative commented, "There is a big management turnover. It causes real anxieties for people and ourselves."

Relatives spoken with confirmed there were no restrictions placed on visiting and they were made welcome in the home. We observed relatives visiting at various times throughout the days we were present in the home.

During this inspection, we saw care plan documentation had been reviewed, however, we found little evidence to indicate people or their relatives were actively involved in the planning of their care. This is important to ensure the staff are aware of people's preferences and how they wish their care to be delivered. We also noted a key worker system had not been embedded as part of culture of the home. This is a system whereby people using the service are linked to a named staff member who has responsibilities for overseeing aspects of their care and support. This meant there was a lack of close oversight of people's needs and wishes, which resulted in shortfalls. The interim manager informed us they would be introducing the keyworker system and a core staff for each person they support to provide consistency and a single point of referral for families. This would provide stability for people in the home.

Records we reviewed for three people showed that staff were knowledgeable about people's individual needs, backgrounds and personalities. However, they told us they didn't always have time to read people's care plans. This meant they relied on the information given during daily handover meetings.

People were dressed appropriately in suitable clothing of their choice. Staff were aware of the importance of maintaining and building people's independence as part of their role. We observed people were prompted to have access to their local community on a daily basis. Although this involved risks, staff had showed resilience to ensure people continued to access their community. We also observed one person had thrived remarkably since our last inspection in July 2017. One staff spoke warmly and positively about their work and the people they cared for. For instance, one member of staff said, "We have really good teamwork. We want to do our best for people."

Arrangements to ensure that people could express their views were not robust. Relatives had not been asked about their opinions and were not involved in planning for the care of their family members.

People were provided with appropriate information about the home in the form of a brochure and service user guide. There was also information about local advocacy services and we saw one person was receiving support from an advocate. There were secure arrangements in place for the storage of personal files.

Requires Improvement

Is the service responsive?

Our findings

There was a policy on how to provide personalised care. Our review showed that three people who lived in the home had individualised care plans based on their assessment of needs. Care plans had been developed which provided personalised details of each individual's daily routines and what worked for each person. We saw these care files contained a personal profile, a person centred support plan as well as a behaviour support plan. We noted that some of the care plans were printed following a 'red, amber green' colour code so important information could be accessed quickly within people's files. The plans were split into sections covering consent and capacity, mobility, communication, diet and nutrition, medicines requirements, personal hygiene and social needs. We also noted cultural and spiritual and any diverse needs were recorded as appropriate. However, we noted that one person who had been in the service for approximately three months did not have a behavioural support plan. We found a comprehensive risk assessment on this person had been completed however, there was no behavioural support plan to provide staff with personalised guidance on how to support the person to minimise the risks identified. This was important due to the complexities around the person's needs and because there was a high rate of agency staff usage in the home. A behavioural support plan would provide agency staff the guidance on people's needs and support. We spoke to the interim manager who immediately started writing the care plan during the inspection.

We found people's communications needs had not been adequately supported. Some of the people who lived at the home had limited verbal communication. Their care assessments had identified communication needs and they had a communication plan which stated that they required assistance using picture exchange communication system (PECS). However, we found the PECS were not adequately developed to ensure staff could communicate with people. Some of the pictures were in kitchen drawers. Staff are meant to carry PECS at all times to aid with interactions. The picture exchange communication system, or PECS, allows people with little or no communication abilities to communicate using pictures. People using PECS are taught to approach another person and give them a picture of a desired item in exchange for that item. This meant that people's communication needs were not adequately met.

Comments from relatives were mixed. They included, "We don't get involved in any care planning or review. They have never asked us what used to work for [relative] when they were with the last provider", "It would be useful if they email care plans, so we can review and make comments sign and return, they have never shown us a care plan." And, "They would ring me and tell me if there has been an incident." And, "We share important information with them, but they don't act on it."

We shared these views with the interim manager who informed us that they are planning to invite relatives in the next few weeks to discuss care plans. This would demonstrate that they are involving relatives in reviews and seeking their input on what works for people.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can

access and understand, and any communication support that they need. We looked at how the provider shared information with people to support their rights and help them with decisions and choices. We observed some of the information displayed in the home had been produced in different formats to meet the communication needs of people living in the home. For example, some posters were written in an easy read format.

We saw there were arrangements in place to review and evaluate people's care plans on a monthly basis. The home had established a system called individual practice workshops to assist with reviews of people's needs and the use of restrictive practice. The systems relied on information completed by staff throughout the month. The practice workshop records that had been reviewed consistently stated, 'Unfortunately it has not been possible to analyse as log book data had been poor' we found this to be the case for more than six months. Apart from these workshops we found care plan reviews were not routinely undertaken in the home. This meant that people's needs were not adequately reviewed to identify if they were making progress or meeting their goals.

Staff completed daily records, which provided information about changing needs and any recurring difficulties. However, we noted that the daily records were of poor quality and did not always reflect what was going on in people's daily lives. The state of the records themselves were also of poor quality. We found pieces of paper had been attached to daily records. This meant there was the potential risk that aspects of people's care were not monitored in a robust way. We checked quality assurance records in the home and found this had been identified as an issue. We also spoke to the operations director and the quality improvement lead regarding this and they informed us that staff would be offered a comprehensive training course on record keeping.

There was a failure to ensure that records relating to care and treatment of people were complete and fit for purpose.

The provider had failed to maintain good governance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

People had access to various activities to keep them occupied. We saw people had activity plans which included outdoor activities such as nature walks and drives. People were supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them, including in the wider community. The service's values and ethos supported people's involvement in community activities and a positive risk-taking approach which enabled people to explore and enjoy outdoor activities. One person's activity plan involved daily walks to the local shop.

We checked to see how the provider supported people to ensure they can have a pain free death. There was no evidence to show that people or their relatives had been offered the opportunity to discuss their end of life preferences. This meant that people could not be assured they would receive the right support in the event of a life threatening illness or incident. We spoke to the interim manager regarding this and they informed us they would be arranging training for all care staff in the home.

We looked at how the service managed complaints. Before this inspection were aware of an ongoing complaint in the service. We discussed with the operations director how the complaint had been managed. We noted that the complaint was ongoing and had not been concluded. They informed us how this had been escalated with the local authority. We also saw evidence of correspondence regarding the complaint. The organisation had followed its policy and regulations related to the receiving and management of complaints.

Some relatives knew how to complain. For example, one relative told us they would talk to a member of staff or the manager if they had a concern or wished to raise a complaint, other people were unsure of the complaints procedure. Other relatives informed us they were unsure who to raise concerns with and what procedures to follow. However, during the inspection, we saw information was available to people and their families about how to make a complaint. This information was displayed in the home.

On the day of the inspection, complaints records could not be located. Following the inspection, we asked for the records and records were submitted to us. We saw concerns had been investigated and responses had been sent to those who had raised concerns.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed at Mather Fold House. However, they were not present at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Following the inspection, we were informed that the registered manager had left the organisation. An interim manager was appointed to oversee the running of the service while waiting to apply to registered as a manager with the CQC.

Before the inspection, we received a significant number of concerns from staff about the operation and management of the home. Staff had raised concerns to CQC about the lack of support they received from the management at the service. They had also raised safeguarding concerns with the local authority about the treatment people received.

At our last inspection we raised concerns regarding unstable leadership and governance arrangements in the home. This was as a result of high turnover in management personnel. During this inspection in July 2018 we found this had continued to be the case. There had been six registered managers employed at the home since April 2016. This lack of consistent leadership had an impact on the quality of care delivered and on the home's ability to move forward and sustain improvements. Our findings demonstrated that there had been no significant improvements made to the quality of care people received since our last inspection. In July 2017 there was one breach of regulation and a recommendation however, at this inspection we found eight new breaches of regulations. This meant that the quality of the care at Mather Fold House had further deteriorated.

We looked at how the provider demonstrated how they continuously learnt, improved, innovated and ensured sustainability in the service. We found there was an established system to assess quality of care and the maintenance of people's wellbeing. There was an internal inspection programme carried out by the provider's compliance department. This followed the CQC style of inspections. We found since our inspection in July 2017, there had been no internal compliance checks by the provider until February 2018. During their checks in February 2018 they found significant shortfalls in the safety of the care provided. They developed an action plan on how the shortfalls would be rectified. However, we found concerns found in February were not addressed for the following three months. In addition, our inspection in July 2018 identified similar concerns to those identified by the provider's internal checks. This meant that there was a delay in ensuring that shortfalls to the safety standards were rectified in a timely manner.

We saw that audits had been undertaken in various areas such as medicines, infection prevention and control and health and safety. They had also kept a record of significant incidents in the home. However, the audit systems were inadequate and not robust to enable the registered manager and the provider to learn from shortfalls and to take immediate action where people's safety was compromised. For example, we found the internal audits had identified that staff were using inappropriate language to describe people in their care records and that there was a lack of adequate records on incidents. However, we also found this

to be the case in July 2018.

Action plans we saw did not have the names of people accountable for completing them and the dates when the tasks needed to be completed. This meant that there was a lack of accountability. As a result, we found shortfalls that had been known to the provider since December 2017, had not been rectified.

The health and safety audits carried out were not accurate or reliable. The audit had failed to identify the faults that we identified around the premises. For example, we found health and safety audits did not take into consideration the storage of cleaning chemicals in the home. We also found shortfalls in infection prevention and control, the care records, and incident records which had not been identified by the audits. This meant that the registered manager and the provider had failed to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience of people using the service.

There was a lack of accountability and oversight in the home. For example, we looked at governance meetings carried out in the home. These were meant to be chaired by the registered manager to discuss progress in the home. However, we found the registered manager had attended only one out of four meetings. This meant that concerns raised at these meetings were not overseen by them. Staff raised concerns that the registered manager was not visible in the home. We spoke to the operations director who informed us that they had been given the impression that the registered manager was present in the home when they were not. In addition, the senior management at the home failed to exercise adequate checks and oversight to assure themselves that the registered manager was complying with regulations. As a result, staff were not provided with appropriate and consistent leadership and oversight to ensure they delivered safe care and treatment.

There were poor systems and processes for dealing with staff who may have behaved in an unprofessional manner. Incidents of abuse and improper treatment of people had not been adequately investigated. We also found disciplinary processes were not overseen by the senior managers or the provider's human resources department, they were not robust and transparent and did not ensure lessons were learned from unsafe practices. This meant that people were at risk of continuing to experience poor care practices from staff in the home.

Systems and processes for training, induction and supervision were inadequate and suitable training had not always been provided to staff to support the delivery of safe care.

We spoke to the operations director of the home regarding the failures above. They informed us that they had identified the failures in March 2017 and had attempted to work with the registered manager to resolve the concerns. They further advised that there were not always given an accurate picture of the shortfalls in the service. However, we would expect the provider to have robust systems in place to oversee the care provided and to hold the registered manager to account.

Best practice and national guidance had not been adequately embraced in the service. We found the care service was aware of the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. However, we found on this inspection that the service was failing to deliver these values. The leadership of the service had not embraced the guidance.

We also noted that the staff and the registered manager had not effectively utilised local initiatives with the

local authority and local clinical commissioning groups in areas such as safeguarding champions and dignity champions. A safeguarding champion had been nominated; however; they had not attended any locally organised workshops at the time of our inspection. These initiatives are promoted by the local authority and local clinical commissioning groups to share best practice and to improve the way services meet people's needs and introduce preventative measures. This meant that the registered provider and the registered manager were not always taking opportunities to learn from best practice designed to improve people's outcomes. Following the inspection, they informed us that they would be contacting the Local Authority and arrange to join in the initiatives.

At our previous inspection we rated the home overall 'requires improvement' and there was one breach of regulation. However, at this inspection we found eight breaches of the regulations and the service was rated inadequate. We noted that there had been a significant deterioration for people's care and safety. The provider had failed to continually evaluate and seek to improve their governance and auditing practice. This meant that the governance systems and processes in place did not enable the provider to identify where quality and/or safety was being compromised and to respond appropriately and without delay.

The provider had failed to maintain good governance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We received mixed feedback from relatives of people who lived at the home. Comments from relatives included, "There is no stability of leadership and staff don't seem to be supported, six managers have left in the last two years", "Repairs and maintenance work is not completed timely, it's taking up to six months", "I think things were being done when the last manager was around, if I had any problems I would go and see [the last registered manager], they could get things done." A member of staff commented, "The new manager is really trying to build positive relationships up with the staff."

The organisation had maintained some links with other organisations. They worked with organisations such as local health care agencies, local pharmacies, learning disabilities nurses, social workers and local GPs. There was a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Mather Fold House. Evidence we saw showed that that professional advice was sought where staff had concerns about people's health.

The provider was informing the Care Quality Commission (CQC) of key events related to people who lived at the home. The registered manager and the registered provider had notified CQC of key events that had occurred in the home.

We checked how people who used the service, the public and staff were engaged and involved in the running of the home. We spoke to three relatives who informed us that they would get phone calls from managers. They advised that there had not been any formal meetings to discuss progress or challenges in the home. In addition, there were staff meetings. However, minutes of the meetings showed that the registered manager and the provider's representatives didn't always attend meetings to share the challenges and expectations.

Some staff we spoke with told us they did not feel the last registered manager worked with them and supported them. "[The registered manager] was not always here so cannot say much about the support."

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. Care staff had delegated roles including medicines management, catering and domestic duties. Each member of staff took responsibility for their role. However, there was a lack of evidence on how the registered manager

was monitoring staff to ensure people were receiving appropriate care that met their identified needs.

We looked at how staff worked as a team and how effective communication was maintained between staff members. There was communication about people's needs among staff and management. We found handovers were used to keep staff informed of people's daily needs and any changes to people's care. However, one relative informed us that information did not appear to be shared among the staff team. They said, "You tell them something, it's not written down and seems to go from one ear out through the other, communication is poor." We spoke to the interim manager regarding these concerns and they informed us they have been working with staff to ensure accountability and effective sharing of information about people's needs.

Following the inspection, we met with the provider's representatives and they informed us they would be taking robust action to address all the shortfalls we identified. They also took immediate action to permanently remove all care staff who had been alleged to have behaved inappropriately against people in the home and to review disciplinary investigations that had not been adequately handled. They submitted an action plan on how they intended to address all other concerns.

The interim manager and the operations director worked with us in an open and transparent manner during the inspection. They co-operated with all our requests for information and evidence. In addition, we found some of the staff we met and spoke to were committed to provide good quality of care.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to fully mitigate the risks to people's health and safety. Regulation 12 (2) (a) and (b) The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. Regulation 12 (g) The provider had failed to operate effective systems for the prevention and control of infections. Regulation 12 (2)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to operate an effective procedure to safeguard people from abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate an effective quality assurance system in order to improve the quality and safety of the service. Regulation 17 (1) (2) The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user including a record of the care and treatment provided to service users.Regulation 17 (1) (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)