Ark Specialist Healthcare LLP

Advent House

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of Advent House took place on 30 November and 12 December 2016 and was unannounced on both days. We last inspected the service on 21 July 2016. At that time we found the registered provider was not meeting the regulations relating to person centred care, consent, safeguarding people from abuse, premises safety, staffing and good governance. The service was rated inadequate and placed into special measures and we took action to require the service to improve. The registered provider sent us an action plan outlining the improvements they would make. On this visit we checked to see if improvements had been made.

Advent House is a two storey purpose built facility which is registered to provide 24 hour accommodation and nursing care for up to 10 people who have a learning disability. The service is accessible for people with a learning disability and who may need to use a wheelchair. The service is located within a quiet residential area with open views to fields. At the time of our visit there were four people who used the service permanently and one person who was using the service for respite care on the day. Nine people used the service for respite care.

The service is required to have 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 service did not have a registered manager at the time of this inspection. The registered manager had de-registered in August 2016; however they continued to work at the service as a registered nurse. The registered provider had deployed an interim manager at the service. A new permanent manager had been recruited, and they commenced employment at the service on the second day of our inspection. They left the service two weeks later and the interim manager remained in post.

At our inspection on 21 July 2016 we found risk assessments for people who used the service were insufficiently detailed. This meant that staff did not have the written guidance they needed to help people to remain safe. At this inspection we found some improvements had been made and risk assessments were in place to provide direction for staff, although risk assessments for one person using the service for respite care had not been updated to reflect current risks.

We found incidents were recorded but not always analysed for trends, and the registered provider did not maintain an overview of incidents to minimise future risks to people.

Emergency plans were not in place in the event of a fire because fire drills had not been regularly completed by all staff to reduce risks to people.

The above issues were a continuing breach of regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse.

At our inspection on 21 July 2016 we found the registered provider had failed to ensure suitably qualified staff were on duty at all times because some people who used the service had been assessed as needing nursing care; however there was not always a nurse on duty. At this inspection we found improvements had been made and a qualified nurse was now on duty at all times. We found there were sufficient, suitably trained staff to meet people's needs.

Safe recruitment procedures were in place, although records were not always available and well organised.

Medicines were managed in a safe way for people.

People's capacity was not always considered when decisions needed to be made to ensure their rights were protected in line with legislation, for example when deciding to use a night time monitoring device. Evidence of mental capacity assessments and best interest processes was not present for everyone who lacked capacity to make certain decisions. This was a continuing breach of regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 21 July 2016 we found staff had not always had the training they needed to support people who used the service effectively. At this inspection we found improvements had been made and staff received training to enable them to provide effective support to people who used the service. For example, staff were now up to date with training in physical intervention techniques, moving and positioning, and gastrostomy care. Staff had also received supervision or appraisal to support them in their role.

Relatives told us people who used the service enjoyed the meals. We saw a choice of meals, snacks and drinks was available. A range of healthcare professionals were involved in people's care as the need arose.

Staff were able to clearly describe the steps they would take to ensure the privacy and dignity of the people they cared for and supported.

Relatives told us staff were caring and we observed staff interacting with people in a caring, friendly manner. Observation of the staff showed that they knew people well and could anticipate their needs.

People were able to make choices about their care, however we found some care records did not reflect people's current needs to provide guidance to staff. At our last inspection we found the registered provider was not meeting the regulations related to person centred care because activities for people were limited. At this inspection we found people were supported to participate in leisure and social based activities; however evidence of activities for some people was still limited. The above issues evidenced a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a system in place to manage complaints. Relatives told us the staff and managers were approachable.

Effective systems were not in place to assess monitor and improve the quality and safety of the service. Whilst issues related to suitability of staffing and support for staff had been addressed, we found continuing breaches of the regulations which had not been addressed. This was a continuing breach of regulation 17 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

Incidents were not always analysed to reduce future risks to people.

Fire drills were not regularly completed to reduce risks to people in the event of a fire.

Suitable staffing was in place to meet the assessed needs of people using the service.

Systems were in place to make sure people received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity was not always considered when decisions needed to me made.

Staff were trained to support people who used the service.

People were supported to eat and drink, and to maintain a balanced diet.

People had access to external health professionals as the need arose.

Is the service caring?

Good

The service was caring.

Relatives told us and we saw staff were kind and caring.

Staff were respectful in their approach and were able to tell us how they maintained people's privacy and dignity.

People were supported to make choices and decisions about their daily lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was planned; however, some care records were not updated to reflect people's current needs.

Activities were provided but this was not at a level which would meet the needs of all the people using the service.

Relatives told us they knew how to complain and said staff were always approachable.

Is the service well-led?

Inadequate

The service was not well led.

Accurate and up to date records were not always maintained.

People were not protected by effective quality monitoring systems.

The registered provider had not taken robust action to improve the quality and safety of the service to people and address the breaches of the regulations we found.

Relatives and staff told us the service had improved in recent months.

Advent 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 registered 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.

We last inspected Advent House on 21July 2016. This inspection took place on 30 November and 12 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector and a specialist advisor on the first day and one adult social care inspector on the second day. An Expert by Experience made telephone calls to the relatives of people using the service to gain their views about the service provided. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection was a family carer of a person with a learning disability.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider and feedback from the local authority safeguarding team, commissioners and other partner agencies. The registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service, including observations and speaking with people. We spoke with three people who used the service, however as we were not familiar with their communication style, we used additional methods to understand their experience. We spent time with people in communal areas observing care being delivered. We spoke with two relatives during the inspection and six relatives on the telephone after the inspection. We looked in the bedrooms of four people who used the service (with permission) and two bedrooms used for respite care. During the inspection we spoke with eight staff; this included the interim manager, a nurse, four support workers, the area manager and the deputy manager. We spent time looking at five people's care and support records. We also looked at three records relating to staff recruitment, training records, maintenance records, and a selection of the service's management records.

Requires Improvement

Is the service safe?

Our findings

The relatives we spoke with told us they felt their family member was safe at Advent house. One relative said, "Yes it's safe. It is well staffed." Another said, "I don't have a question with that. [Name] has two staff to get them ready and to change them." A third relative said, "Absolutely, yes. When I go into Advent House they have a secure locking system."

At our last inspection in 21 July 2016 we found Incidents were recorded, however they were not analysed to reduce the risk of reoccurrence. This constituted breaches of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we checked to see if improvements had been made.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. The interim manager and staff members were able to describe the procedure to follow and explain what action had been taken following accidents and incidents. We looked in the incident report folder and sampled five incident reports.

Two incident reports contained information about how to prevent future incidents and reduce risk to people. However three of the five incident reports we sampled had not been checked by the interim manager. Two incident reports had not been reviewed for the cause of the incident and did not detail measures put in place to reduce future risks to individuals. This included one incident from September 2016 where staff had been assaulted and injured during a behavioural incident. This showed people were not always protected from the risk of harm because incidents and accidents were not always analysed.

The number of incidents occurred in any one month were sent to the registered provider as part of a monthly operations report. We saw from the monthly report in July 2016 23 incidents were recorded but there was no record of overview, analyses or action taken to reduce incidents by the registered provider. No monthly operations reports had been completed since July 2016 and there was no evidence action had been taken by the registered provider to address this. We asked the interim manager how trends and patterns in incidents were analysed and managed to reduce risks to people. They told us they were intending to start an overview and analyses record in December 2016 and showed us the blank document. This meant appropriate action was not always taken to reduce risks to people who used the service and keep them safe.

We saw a multidisciplinary team of community professionals was now involved with one person whose behaviour challenged others at times, and they were analysing and advising on how to best manage the behaviour and reduce future incidents.

At our inspection in July 2016 we found the registered provider was not meeting the regulations relating to safe care and treatment, because risk assessments and behavioural support plans were not in place for one person, in order to guide staff to reduce the risk of harm to people. At this inspection we found some

improvements had been made.

The members of staff we spoke with understood people's individual risks and how to ensure risks were minimised whilst promoting people's independence. We looked at five care records of people who used the service and saw risk assessments were in place for a range of issues including keeping healthy and active, behaviour that may challenge others, choking, cooking, risks related to specific health conditions, mobility and falls. The care file of one person identified risks when they were in the kitchen, such as cuts when using kitchen appliances, and scalds with hot water. This care plan also identified behaviours that may challenge others and clear action for staff to follow to ensure the safety and wellbeing of the person. We saw risk assessments for people using the service on a long term basis were reviewed regularly and were up to date. However risk assessments for one person using the service for respite care had not been updated to reflect changes in the person's complex health needs.

We looked at the emergency procedures in place. The fire file contained a risk assessment dated 29 January 2016 and records indicated that system testing and maintenance was carried out in September 2016. The last recorded fire drill and evacuation was 09 March 2015 and the staff we spoke with could not recall completing a fire drill. Following our inspection the area manager informed us the date was inaccurately recorded and this was March 2016. There was no documentary evidence that a fire drill had taken place on 09 March 2016, however information provided after the inspection indicated a fire drill had taken place involving eight people, including at least three service users, of the 26 staff. Prior to this the last recorded fire drill was in June 2015, 17 months prior to the inspection. This shows most staff had not completed a fire drill in line with the registered provider's policy. This meant the registered provider was not doing all that was reasonably practical to reduce risks to people in the event of a fire. The interim manager said they would arrange a fire drill for the day following our inspection. The above issues were a continuing breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 21 July 2016 we found a qualified nurse was not always on duty at the service and evidence was not available around the specific nursing needs of people to evidence this was safe. After the inspection we contacted NHS Wakefield Clinical Commissioning Group who confirmed a registered nurse was required to be on duty at all times for some people who used the service. Following the inspection we took action to ensure a nurse was on duty at all times. In addition we raised safeguarding alerts to the local authority.

At this inspection we looked at duty rotas and spoke with staff to determine whether there was sufficient staff with the right skills and qualifications on duty at all times. We identified there was always a nurse on duty day and night to cover the service 24 hours a day.

We found agency nurses were used to cover almost all night shifts and some relatives we spoke with expressed concern that agency nurses did not know their relatives' complex needs. One relative we spoke with said, "They have agency staff working there. They have a lot of Agency staff in a lot of the time." The manager showed us they were recruiting for permanent nursing staff and the agency staff being used were almost always regular and had gained familiarity with the needs of people who used the service.

The manager told us the number of staff on duty depended on the number of people using the service. On the first day of the inspection there were five people using the service (four on a permanent basis and one for respite care later in the day). The registered manager told us there were usually six care staff and a nurse on duty to meet the needs of people who used the service. We found sufficient, suitably trained staff were deployed to meet people's needs in a timely way and keep them safe. Another relative told us, "They have cancelled quite a few visits. I was supposed to go at 1pm today but they cancelled. I spoke to a Deputy

Manager. She said would I mind leaving it as a member of staff is off sick." The manager told us in the event of staff sickness, permanent staff were asked to cover shifts first. They said agency staff were used to maintain the service to people if permanent staff could not cover. This showed the service had contingency plans in place to enable it to respond to unexpected changes in staff availability. However, due to people's complex needs and the allocation of two to one and three to one staffing to reduce risks to people, last minute staff sickness could result in some people's activities being limited.

At our last inspection on 21 July 2016 we found the registered provider had not done all that was practical to reduce risks to people from unsafe premises, for example, by checking water temperatures at the service to reduce the risk of legionella. At our inspection on 30 November 2016 we found water temperature checks for taps basins and shower heads were last recorded on 13 September 2016 and not monthly. Following our inspection the area manager sent us an electronic record of some water temperature checks completed on 01 November 2016. This meant safety checks were completed to ensure building safety.

We looked at other records to confirm checks of the building and equipment were carried out to ensure they were safe. We saw documentation and certificates to show relevant checks had been carried out on the fire extinguishers and electrical installation. In addition, the fire alarm system, gas boiler and lifting equipment had been serviced.

We looked at the recruitment and selection processes in place. We sampled files for three of the most recently employed staff and found they did not contain evidence that comprehensive pre-employment checks had been made. This included written references, the completion of an application form and obtaining a Disclosure and Barring Service check (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults and help employers make safer recruitment decisions. We saw only one reference was present for one employee; a second was forwarded to us following the inspection. The interim manager told us the staff member had commenced employment with the service in August 2016 and the second reference was received in September 2016. The manager told us the staff member had not worked unsupervised during this period. In March 2017 the registered provider forwarded records that the staff member commenced employment at the service on September 13 2016. The interim manager had completed an audit of staff files; however accurate and up to date records required to effectively manage the service safely were not readily available. This contributed to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection people who used the service were unable to administer their own medicines. Blister packs were used for most medicines at the home, as well as some medicines in bottles and boxes. We looked at people's medication administration records (MAR). A MAR is a document showing the medicines a person has been prescribed and is used to record when they have been administered. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. Medicines were counted after each administration to ensure accuracy.

Some prescription medicines contained drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded.

Creams and ointments we saw were dated upon opening and found to be in date. Body maps were in place to guide staff as to how and where to administer creams.

People's medicines were stored safely in a locked room. We saw the drug refrigerator and controlled drugs

cupboard provided appropriate storage for the amount and type of items in use.

We observed one person was administered their medicine through a Percutaneous Endoscopic Gastrostomy (PEG). This is a way of introducing foods and fluids directly into the stomach. The staff member spoke with the person throughout and showed good skills in administration.

In the records we sampled we found people had individual 'as required' (or PRN) medication protocols. PRN protocols provide guidelines for staff to ensure these medicines are administered in a safe and consistent manner. This meant people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

Fridge and room temperatures were recorded but there were several gaps in the recording where temperatures had not been entered. No other areas of clinic room management were being audited at the time of this inspection, including cleaning; although the manager informed us cleaning was completed nightly. We saw no audits of medicines administration had been completed to ensure compliance with the registered provider's policies. The manager showed us a number of audit forms they intended to implement across the service, including medicines audits, however these had not yet been completed.

We saw nurses and senior care workers administered medicines at the service and completed online training in relation to medicines administration. Medicines administration was always witnessed by another member of staff. Whilst medicines administration was appropriate there was no evidence competence assessments had been completed to ensure staff had the appropriate skills and knowledge to administer medicines safely. The manager told us this was an area to address and they planned to introduce three-monthly assessments.

We found the service was clean and well maintained and personal protective equipment was available throughout the service to support infection prevention and control. There was a mal odour in the self-contained flat of one person who used the service, which was related to the person's behaviours. The interim manager described action that had been taken to reduce this odour and also told us they planned to replace the carpet with alternative flooring to improve the person's environment and protect their dignity and health.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty 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) authorisations.

At our last inspection on 21 July 2016 we found the service was not meeting the requirements of the MCA. At this inspection we checked to see if improvements had been made. We found the staff we spoke with had received training and had an understanding of the MCA and DoLS.

We found no mental capacity assessments had been completed by the service around the restrictions in place for one long term resident. This was despite their being subject to a DoLS authorisation, which indicated they had been assessed as lacking capacity to make the decision to use the service for the purposes of care and treatment.

For two out of four long term people using the service mental capacity assessment and best interest paperwork had been completed and was signed by managers and nurses from Advent House, however there was no evidence of consultation with relatives, representatives or community professionals involved with each person. For example, we saw a 'Record of actions taken to make a best interest decision,' around the decision to have a healthy diet in one person's care records, which stated the family were involved in the decision, however no records of contact or signatures from relatives were evidenced. 'Social work meetings when moved in' was also cited as evidence a best interest discussion had taken place; however there were no records of these meetings.

DoLS standard authorisations were in place for four people who used the service long term. The service had not completed DoLS applications for people who used the service for respite care and the respite care record we sampled contained no mental capacity or best interest information, although the persons complex needs indicated they lacked the capacity to make complex decisions, such as consenting to the use of bed rails and a night time monitoring device. We discussed this with the interim manager who told us they had prioritised people using the service long term and planned to review people using the service for respite care in the coming months. This meant people's mental capacity and best interests was not always considered when decisions needed to be made in line with the MCA.

The above issues evidenced a continuing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However for one person using the service long term we saw examples of good practice in relation to best interest decision making where a mental capacity assessment and best interest decision was documented in relation to restrictions used to keep the person safe from harm. This included discussions around the least restrictive options and contributions and signatures from community professionals and the person's relative.

When asked if they thought staff at Advent House had appropriate training one relative said, "They are trying to train the staff up." Another said, "They seem to know how to do their jobs." A third relative said, "Sometimes yes and sometimes no. It depends who's on (duty)."

At our inspection in July 2016 we found the registered provider was not meeting the regulation relating to staff training because staff were not always trained to support people who used the service.

At this inspection we found improvements had been made and training had been delivered in key areas to ensure staff had the skills and knowledge to effectively support people. This included physical interventions, gastronomy care and moving and handling. The staff we spoke with were knowledgeable about how to de-escalate situations and told us they did not work with people who might experience behaviours that may challenge others until they had completed several days of training. One staff member said, "Yes the training has been good. I am trained to do physical intervention and moving and handling and I am starting my NVQ now too."

We found new staff received an induction and were supported in their role. One staff member said, "I looked through support plans, had a tour of the building and did online training. I was shadowing for three months as I didn't have moving and handling training. The training was very useful. I did behaviour management. I couldn't work with [name of person] until I did it."

At our inspection in July 2016 we found staff had not consistently received supervision and appraisal from 2014 to the date of the inspection. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. At this inspection the staff we spoke with told us they had recently received supervision. We found the manager had implemented supervision and appraisal at the beginning of November 2016 and supervision or an appraisal had now been completed with all staff members who were not absent due to ill health.

One relative said, "They give [my relative] a healthy lifestyle. They give [my relative] different options and [my relative] can pick things." Another relative said, "There is no problem dietary wise. The food is cooked on the premises." And third relative said, "[My relative] really enjoys the food. They ask [my relative] what [they] likes. Sometimes they have a take away as a treat."

We looked at the home's menu plan. The menus provided a varied selection of meals. Staff told us menus had been devised with people who used the service. We saw a pictorial menu was on display offering choices at each meal time and people were encouraged to be involved in food preparation and cooking.

We observed the lunch time of two people who used the service. The meal was relaxed and people who were able told us they enjoyed the food provided. Those people who needed help were provided with assistance.

The service kept an overview of people's specific nutritional requirements and two people were being supported to lose weight and achieve a healthier lifestyle. However we saw people had not been weighed monthly, as stated in their care plans, since September 2016. The manager told us they would address this

straightaway.

We saw people had hospital passports. The aim of a hospital passport is to provide hospital staff with important information they need to know about a person with a learning disability when they are admitted to hospital. Hospital passports we saw contained information that would help to ensure care and treatment would be provided in a way the person liked.

People had access to external health professionals as the need arose. People were supported and encouraged to have regular health checks and were accompanied by staff to hospital appointments. Staff told us they knew people very well and could often tell from their non-verbal communication if they were unwell. People's care records showed a range of health professionals were involved, including psychologists, occupational therapists, physiotherapists, GPs, hospital consultants, community nurses, chiropodists and dentists. This meant people who used the service received additional support to maintain their health.

The design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service, however we saw a self-contained flat used by one person had limited decoration and was stark. Some work had been completed to make the flat more homely for the person, such as stencilled drawings on their wall. Picture frames presented a risk due to the person's behaviour, which could challenge others at times. However, there were a number of unpainted areas of the walls where plaster had been replaced. The interim manager told us they would address these issues to promote a more suitable environment.

Good

Is the service caring?

Our findings

Relatives of people who used the service we spoke with told us they thought the staff at Advent house were kind and caring. One relative said, "There is a homely feel because of how nice the staff are." Another said, "The staff are very good. [My relative] bakes with them, they interact with [my relative]. The staff are excellent. They always give [my relative] choices." Other comments included, "The care is absolutely fantastic. All the support workers are friendly. They are really welcoming. [My relative] enjoys going there and likes everybody", and, "The staff are all lovely and are genuine, nice people."

Staff we spoke with told us they enjoyed supporting people who used the service. One staff member said, "I like the residents. You get close to them. You can make a difference." Another said, "I love it. The residents are like a little family. Lately it has improved. I like being a (staff member) here. I like the people."

Staff had a good knowledge of people's individual needs, their preferences and their personalities and they used this information to engage with them in meaningful ways. We heard staff chatting with people about family members and special occasions. Staff told us they spoke to people, or their family members, about their likes or dislikes and spent time getting to know them during their induction to the home. Care files contained detailed information about the tastes and preferences of people who used the service and staff told us they had an opportunity to read these records before commencing work with people. This gave staff a rounded picture of the person, their life and personal history.

People were supported to make choices and decisions about their daily lives. We saw people could choose what time to get up or go to bed, what to eat and what clothes they wished to wear. We observed staff had a good understanding of people's communication style and picture cards were used to support people's menu choice. Staff were aware of how to access advocacy services for people if the need arose. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. This meant the choices of people who used the service respected.

During the inspection we spent time observing staff and people who used the service. We saw staff interacting with people in a caring and friendly way. Staff were respectful when speaking with people. One staff member spoke to a person about their family and what they were going to do that day. Staff joked with people and the people we saw smiled and enjoyed the banter. We observed staff also bent to people's level to talk with them and used appropriate touch to engage with them. We saw there was a good level of interaction that was warm and spontaneous.

Before care and support was provided, staff talked with people, requested consent and explained what they needed to do. For example, when administering medicines or supporting a person to transfer using a hoist.

Staff described how they respected people's privacy. They told us they always knocked on people's doors before entering and made sure they were covered with towels when they were providing personal care. Staff members said how important it was to ask the person's permission before providing care and to tell them what they were going to do. Staff supported people with their personal care in a discreet and dignified way.

Most people's rooms were personalised to their taste, with family photographs, art works and personal items. One person told us they had chosen their wall colour. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

Staff told us how they encouraged people's independence on a daily basis and care records contained detailed instructions for staff on how to support people's independent living skills. For example, '[Name of person]will choose what [name] wants to drink. Will get a cup, put the kettle on, and pass the milk and get a spoon out of the drawer."

We found people did not have end of life plans from which staff members could take direction although some people using the service had life limiting conditions. The interim manager told us many relatives did not wish to discuss this, however, they planned to address this in the coming months.

Requires Improvement

Is the service responsive?

Our findings

Some relatives told us they had been involved in reviewing their relatives care. One relative said, "They do involve us in reviews. Yes they meet [my relative's] needs well. They are very good." Another told us they had attended their relative's review meeting recently. One relative told us they felt listened to in regular meetings with the service and the community team.

Some relatives told us they had not been involved in reviewing their relative's care. Comments included, "It has never been mentioned." and "[My relative's] care Plan was atrocious and bore no resemblance to [my relative]." We discussed this concern with the interim manager and they said the key nurse for the person would address it straight away.

At our inspection on 21 July 2016 we found the service was not meeting the regulations related to person centred care, because care plans did not always provide sufficient information to enable staff to provide safe care and treatment.

At this inspection we found more detailed plans in the care records of people using the service long term to provide direction for staff. We saw care plans for people using the service long term were largely up to date. The manager said people's care plans were reviewed as soon as their situation and needs changed, and every month. However, we saw the personal care plan of one person using the service long term had not been reviewed since September 2016 and their weight had not been recorded monthly, as stated in their nutritional care plans. These reviews help in monitoring whether care records were up to date and reflected people's current needs so any necessary actions can be identified at an early stage.

The care records we sampled for one person using the service for respite care had not been reviewed or updated since May 2016, and the person's relative told us of a significant deterioration in their health since that time. This included changes to their complex personal care and health needs. We saw these changes were not recorded in care plans to provide direction for staff. The interim manager told us they did not think the person had used the respite service recently, however, we saw from daily records the person had accessed the service the weekend prior to this inspection. This meant there was a risk of unsafe or inappropriate care being delivered because care plans did not reflect people's current needs.

This was a continuing breach of Regulation 9 (3) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with knew the person's needs had changed and how care should be delivered. We asked the interim manager how staff new the person's needs had changed. They said information was shared verbally at handovers and staff meetings and updates from the person's relative were put in the communication book for all staff to read. The interim manager told us they had prioritised the care plans of people using the service long term and they would ask the key nurse to update the persons care records straight away. We checked the daily records from the person's last stay to ensure care was provided in line with their current needs. Night time observation records were not available no one on duty could locate

them. The manager said an agency nurse had been on duty that weekend and may not have completed the records. The records were located following our inspection and evidenced appropriate checks had been completed to keep the person safe and well. We discussed this with the interim manager, who told us they would ensure up to date records were always available for staff and managers to review to ensure safe, person centred care had been delivered. This contributed to a continuing breach of Regulation 17 (2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection a meeting for senior staff and nurses was held as planned to allocate keyworker roles and responsibility for monthly reviews of care plans.

Through speaking with people who used the service and staff we felt confident people's views were taken into account in the delivery of their care. We saw staff at Advent House were responsive to people's needs, asking them questions about what they wanted to do and planning future activities.

The staff we spoke with had a good awareness of the support needs and preferences of people who used the service. Care records included a personal history and personal details were included for example, food preferences. One care record we sampled described the person's interests as, "Enjoys walks out with staff, making craft items and sensory room." This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

In the care records we sampled we saw detailed care plans were in place covering areas such as mobility, nutrition, communication, behaviour that may challenge others, mood, sleep and personal care. Most care plans contained sufficient detail to support staff to deliver effective care, for example, details of how to position a person when sleeping to reduce the risks to their health and wellbeing. We saw care plans were also in place for people's specific health conditions, such as epilepsy, including details of rescue medicine and how this should be used in the event of a seizure. Care plans recorded what the person could do for themselves and identified areas where the person required support. They also contained the person's long term goals, for example, for one person this was to lose weight.

At our last inspection we found activities for people were limited. At this inspection we saw some improvements had been made, however records showed outings were still not always delivered in line with people's care plans. In addition feedback from relatives regarding staffing and people's access to activities was mixed. One relative said, "I think it is very good. [My relative] is in a routine and gets out. They take [my relative] on holidays. They take them on the beach. They take [my relative] shopping to Asda and the park next door. They like walking."

However, five other relatives felt that whilst activity levels had improved in recent months there was still more that could be done to meet their relative's assessed needs. Comments included, "They should do activities with [my relative]," "It is the lack of activity. It depends on the staff who are on and what they do with them. There could be more interaction", "There is a lack of activities. On an odd occasion [my relative] will go to a shop, go for a walk or go to the cinema. They said they would be taking [my relative] out all the time", and, "[My relative] would go out every day if they could. They do go out more frequently now."

We saw from records of the week beginning 30 October 2016 one person who liked to go out frequently only went out with staff from the service once, to the shop. Four outings with family were recorded, two days were left blank and on one day personal care was recorded as an activity. The person's family was struggling to keep up with taking them out and their allocated support hours for outings were not being met by the service. On two occasions that week 'board games' were also recorded as activities within the home. During the week beginning 28 November 2016 two outings were recorded for this person on their activities record

and five days were left blank.

One person with complex behavioural needs was supported with home based activities as they were unable to go out due to risks to themselves and to members of the community. Community professionals from the learning disability team, including an occupational therapist, had provided advice and support to staff on ways to safely engage the person in activities within the home with a view to developing future activities outside the home. Records showed staff were engaging in these activities with the person on some occasions. The manager told us staff had been asked to record any activities with this person within the home, or if activities did not take place, the reason for this. However we saw the person's activity record was blank on six days in November 2016. This meant activities for people were not always evidenced to show person centred care was being delivered in line with their assessed needs. There was no evidence activity records had been audited or action taken to address these issues. This was a continuing breach of regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw more activities were evidenced for one person using the service in their activity planner. On the four weeks of records we sampled they had taken part in activities outside the building three or four times each week. Some activities within the home were also recorded, although some records were also left blank.

Staff told us people were involved in activities and outings. We were told people liked to go shopping, bowling, to the cinema and take part in arts and crafts. One person who used the service attended college for one day a week.

On the first day of our inspection we saw activities were taking place with people. A member of staff was interacting with one person using a tablet computer, and we saw staff help one person to do a jigsaw and go out for a walk to a local beauty spot. Two other people who used the service spent time in the sensory room. This is a special room designed to stimulate a person's senses, usually through special lighting, music and objects. The family of another person who used the service took them out in the afternoon. This showed some activities were provided to meet people's social needs.

Relatives we spoke with told us they would be confident to express concerns to the interim manager and felt these would be acted on. One relative we spoke with said, "The complaints procedure is on the wall. We had a meeting about a complaint we made." They said the service had taken action following their concern, which made them feel better that the service was sorting things out.

The majority of people who used the service were unable to express their concerns verbally, however staff told us they carefully watched people's body language for positive and negative responses to areas such as food, drinks, activities and outings, to determine if people were happy. The manager said they spoke with and observed people on a daily basis to make sure they were happy.

Staff we spoke with said if a person wished to make a complaint they would facilitate this. The complaints record we saw showed where people had raised concerns these were documented and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

We asked relatives of people who used the service if they had confidence the service was well-led and the response was mixed. One relative said, "Yes it's well-led. Things have radically changed since [name of current manager] has come. [Name of current manager] has been good. It needed a radical shake up. I would recommend it. I give it nine out of ten." Another relative said, "[My relative] seems happy and is always smiling. It is a pretty good company."

Other comments from relatives included, "I don't know who the managers are. A couple have left. They are trying very hard to get it right", "It is not well-led or organised. The staff try but they need more nursing staff and more qualified staff. It is such a lovely place and has a lovely, relaxed atmosphere", and, "The Managers have changed. I'm not sure why. Those Managers were making the promises at the beginning. Instead of having agency staff in all the time they maybe should employ more people. I can't fault it. It is a really nice place."

The service did not have a registered manager at the time of this inspection. They had been registered as manager of the service in April 2016 and had applied to de-registered in August 2016, but continued to work at the service as a registered nurse. The registered provider had deployed an interim manager to cover the position. At the time of this inspection a new permanent manager had been recruited. They commenced their induction at the service on the second day of our inspection, however left the service after two weeks in post and the interim manager remained in post.

Staff told us they felt supported by the interim manager. One staff member said, "Yes I feel supported by the company and [name of manager]. I think the company provide good resources and equipment." Another said, "It can be a bit chaotic at times, but I can praise the (interim) manager for daily recording improving." Some staff we spoke with felt the registered provider could do more to support staff and managers at the service.

At our inspection on 21 July 2016 we found the registered provider was failing to keep an overview of incidents and accidents to reduce risks to people. At this inspection on 30 November and 12 December we found improvements had not been made. Incidents were recorded; however there was no evidence of analyses of patterns to reduce the risk of reoccurrence. This was a continuing breach of regulation 17(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 21 July 2016 we found quality monitoring systems were minimal and ineffective. At this inspection we checked to see if improvements had been made. We found information required to effectively manage the service was not always available to staff and managers. For example, the manager had completed an audit of recruitment records indicating which records needed action to ensure safe recruitment could be evidenced, however we found in two of the three records we sampled as part of this inspection the information was still not available, for example following the inspection the manager located a reference for one person on the email of the former manager and forwarded it to us. This showed the oversight of staff recruitment records had not been effective and accurate records were not always kept to

support safe recruitment processes.

As discussed earlier in this report, records related to fire drills were inaccurate and some building management information could not be located. There was no evidence of care file audits, competence checks on staff or medicines audits, to ensure staff complied with the registered provider's policies and procedures. We found night check records could not be located for one person and incomplete activity records had not been addressed by managers. The respite care plan we sampled had not been reviewed or updated despite significant changes in the person's health. The mental capacity and best interests of people using the service for respite care had not been considered by the registered provider. We found three people's weight had not been monitored monthly in line with the care plans. There was no evidence of care plan audits to identify and address these issues.

This meant appropriate records were not always kept and records were not being regularly reviewed by senior staff at the service to ensure safe care and treatment was being provided.

The above issues evidenced a continuing breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered provider was failing to keep an overview of the service and put effective measures in place to improve quality and safety. The only overview of the performance of the service was through the monthly operations report, which had not been completed since July 2016. We saw this contained minimal information. There was no evidence the registered provider checked the service was delivered in line with their policies and procedures, or that they had an overview of the performance of the interim manager. Oversight by the registered provider specified in their response to CQC following our last inspection in July 2016, such as monthly operations reports and four to six-weekly documented supervision of managers at the service had not been completed. The area manager told us the manager would ring for support when required and their supervision had been planned for the first day of this inspection.

The area manager provided a list of their visit dates to the service following our inspection, which included attending managers' meetings, maintenance meetings and a nurses' meeting. They also added dates from their diary when they had provided information to CQC and worked with the manager of the service, although the content of these meetings and actions completed was not recorded, as specified in the action plan sent to CQC following our last inspection. There was no evidence of management "walk arounds" by the registered provider, competence assessments of managers or quality visits, or actions taken to monitor and improve the quality and safety of the service.

The interim manager showed us a 'to do' list of actions required they had drafted, but the dates for completion and name of the responsible person was blank.

Whilst issues related to suitability of staffing and support for staff had been addressed, we found continuing breaches of the regulations relating to safe care and treatment, consent, person-centred care, keeping accurate records and governance, which had not been fully addressed since our last inspection on 21 July 2016. Our observations at inspection highlighted that information was not being routinely collated and analysed. This meant that the registered provider was failing to effectively assess and monitor the quality and safety of the service.

The above issues evidenced a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager told us that they had an open door policy and people who used the service, relatives and staff could approach them at any time. This was confirmed by the people, relatives and staff we spoke with.

Staff told us they had regular meetings where they were encouraged to share their views. They told us that staff worked well as a team. One staff member said, "We work together as a team, everybody supports each other and I have been very well looked after since I have been here." Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people using the service.

The interim manager told us they did not hold any formal meetings for people who used the service as many of the people had complex needs and were unable to communicate verbally. Staff told us they would observe people's body language and actions to find out if people were happy. The manager told us those people who were able to communicate were encouraged on a daily basis to share their views.

Meetings for relatives were not held, however a feedback survey was usually conducted annually. At our last inspection in July 2016 we found feedback surveys had been sent and returned by some visiting professionals and relatives, but there was no evidence the concerns raised about lack of activities for people had been fully addressed. The registered provider had not requested any formal feedback from people using the service, relatives or professionals since our last inspection in July 2016.

On 30th November we found the most recent CQC ratings for the service were not displayed at the service in line with Regulation 20A of Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, however as this was less than 21 days since the publication of the last CQC inspection report the registered provider was not in breach of the regulations related to displaying ratings. We sent the registered provider a copy of the guidance to ensure they were aware of their responsibilities to display the most recent performance assessment rating of their regulated activities.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit statutory notifications to CQC when certain incidents happen. At our last inspection the registered provider had not notified CQC of a number of safeguarding issues in line with legislation. This was a breach of Regulation 18 (2) (e) of the Care Quality commission (Registration) Regulations 2009 (Part 4). At this inspection we found improvements had been made and we did not find any incidents that had not been reported to CQC in line with legislation.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care records did not always reflect people's current needs. Activities for people were not always delivered in line with their assessed needs. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments and best interest decisions were not always completed in line with legislation (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not done all that was reasonably practicable to mitigate risks because incidents were not analysed to prevent the risk of re-occurrence (1) and (2) (a) (b) Fire drills had not been regularly completed. (1) and (2) (a) (b) Risk assessments were not all up to date to reflect current risks

(1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and up to date records were not always kept. (1) and (2) (c) Quality monitoring systems were minimal and ineffective. (1) and (2) (a) (b) (f)