Huntercombe Homes (Ilkeston) Limited

Nottingham Neurodisability Service - Aspley

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 8 November 2016. The inspection was unannounced. Nottingham Neurodisability Service - Aspley is a purpose built unit providing health and personal care for up to 32 adults. On the day of our inspection 31 people were using the service.

The service did not have a registered manager in place at the time of our inspection. The registered manager left the service in August 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from risks associated with their care and support. Staff were not always deployed in a way which ensured people received care and support when they needed it and medicines were not always managed safely. People were supported by staff who knew how to recognise abuse and how to respond to concerns.

People were supported by staff who did not always have the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions but people who lacked the capacity to make certain decisions were not always protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and staff were monitoring and responding to people's health conditions.

People lived in a service where staff knew their likes and preferences. Staff cared about the individuals they were supporting.

People's support needs were not planned for appropriately. There were inconsistent activities to provide people with a stimulating life based on individual needs and preferences. People knew how to raise concerns and felt these would be listened to.

The systems in place to monitor the quality of the service were not always effective and this had led to deterioration and breaches of regulation being found. People were involved in giving their views on how the service was run and the management team were approachable and supportive.

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 consistently safe.

People were not always protected from risks associated with their care and support.

Staff were not deployed in a way which ensured people's needs were met in a timely way. Medicines were not always managed safely.

The risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who had not all received appropriate training and supervision.

People made decisions in relation to their care and support but people who needed support to make decisions were not always protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Is the service caring?

Good

The service was caring.

People lived in a service where staff knew their likes and preferences. Staff cared about the individuals they were supporting.

Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were not always planned for to ensure staff knew how to support them safely. People were not always given the opportunity to live a fulfilling life.

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to monitor the quality of the service were not always effective and this had led to deterioration and breaches of regulation being found.

The management team were approachable and people were involved in giving their views on how the service was run.

Nottingham Neurodisability Service - Aspley

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected the service on 8 November 2016. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service.

During the visit we spoke with six people who used the service and the relatives of three people who used the service. We spoke with three members of support staff, a senior member of staff, two qualified nurses, the activity organiser, the cook and the unit manager. We looked at the care records of seven people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service including audits carried out by the unit manager and registered provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Risks to individuals were assessed and staff had access to information on the individual risks people faced. Risk assessment tools had been completed to assess people's risk of developing a pressure ulcer, nutritional risk, choking and falls. In addition, individual risk assessments had been completed to assess risks to people such as people's ability to use a call bell, and risks associated with behaviours others may find challenging, and these were reviewed monthly.

However, the care plans in place to inform staff how they could minimise these risks with interventions were not always being implemented and the care plans did not always reflect the care being provided. For example, it was stated in the care plan of a person who had fallen on a number of occasions and had suffered fractures as a result of falls, that they would be continuously supervised when they were out of bed. However, the manager said it was not possible to maintain this level of supervision and their funding did not allow for this. This meant that the person did not receive the care that they had been assessed as needing to maintain their safety.

People were not always protected from risks in relation to equipment used to support them. An incident had occurred at the service a year prior to our visit in which a person had become trapped in the bed rails placed on their bed to prevent them falling out. A root cause analysis had been undertaken to identify lessons that could be learnt to reduce the risk of a reoccurrence. An action plan had been developed as a result and we looked at whether the actions had been implemented. We found some actions had been completed, such as the revision of the bed rails policy and individual risk assessments and care plans, but other actions had not been fully implemented. For example, the action plan stated a training day for staff was being arranged, however, we were told this had not taken place and instead awareness of the risk was discussed at a staff meeting. The policy stated a monthly maintenance check would be completed on each set of bed rails but due to the maintenance post having been vacant for a lengthy period this had not occurred. Hourly checks had been introduced when bed rails were being used but we found gaps in the recording of these, indicating they did not always take place as intended.

We saw there were systems in place to assess the safety of the service such as fire risk and the risks of legionella. Staff had been trained in relation to health and safety and how to respond if there was an emergency in the service. On the day of our visit staff were being given practical fire evacuation training. However, we saw that there was a lack of effective care planning in place to support staff to evacuate people in the event of a fire. A bedroom risk assessment had been completed for each person and this document contained information about the support the person would require in the event of an emergency evacuation of the building. However, this information was not easy to identify in an emergency and was very basic in detail.

Prior to our inspection we received information from external health emergency staff and they raised concerns that when they attended the service in an emergency there was a lack of information available about a person's needs and wishes. During our visit we found that records designed for people to take with them in an emergency, such as hospital admission, were not completed in full to ensure staff in other

services would know their needs. For example one person had epilepsy and this was not recorded on their 'traffic light assessment', which would accompany them to other settings in an emergency.

We saw that thickening agents for people requiring thickened fluids was kept in areas where it could be accessed by people using the service. A national safety alert was issued in relation to these agents and recommended they were stored out of the reach of people who may not understand their use due to the potential risk of people choking on the agents.

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

Staff were not always deployed in a way which ensured people's needs would be met in a timely way. One person we spoke with told us they felt there needed to be more staff on duty at the weekend and were, "Concerned with senior management and staffing levels." Prior to our visit we received information of concern about the lack of staff available to support people whilst the night staff carried out a hand over of the day's events. We spoke with a member of staff about the handover and they confirmed that when the new shift arrived, the nurse gave a handover to the staff arriving for duty and the rest of the staff team went home. They said if someone rang their call bell one of the staff from handover would respond, but there were no staff available to supervise people who used the service during this time.

Additionally we saw there were long periods of time where there was a lack of staff presence in the main lounge of the service where people were sitting. Most of the people in the lounge had communication difficulties and could not call for assistance or use a call bell. During the time we observed the lounge a person's pillow used to support their arm fell to the floor twice, it was at least 10 minutes on one occasion until a member of staff entered the lounge with another person and re-positioned the pillow. On one occasion the pillow dropped to the floor and another person who used the service picked the pillow up and was attempting to place it under the person's head. We had to intervene and suggested the person use the call bell to summon staff instead as they appeared to be quite overbearing to the person. They did this and staff arrived quickly.

The unit manager told us that they worked to a set baseline of staff on duty but that if people's needs changed or there were planned appointments then staffing levels were increased. Staff we spoke with said they felt there were generally enough staff to meet the needs of people who used the service. A nurse told us that the number of permanent nurses currently employed did not allow staffing levels to be met without the use of bank and agency staff. However, they said the bank staff knew the people using the service well and there was an agency nurse who regularly worked at the service.

People had been assessed as not being able to administer their own medicines and so relied on staff to do this for them. People we spoke with told us that staff gave them their medicines when they were supposed to. We observed the administration of some people's medicines and saw staff checked again the medicines administration record (MAR) and stayed with each person until they had taken their medicines. The medicines trolley was locked when unattended.

However, we found the medicines systems were not always safe and people did not always receive their medicines when they should. There was a lack of protocols in place to inform staff when some people may need medicines required as and when they were needed. We talked with staff about the ordering and supply of medicines and we were told medicines were supplied every three months rather than the usual four weekly cycle. This meant it was more difficult to monitor the stock levels. In addition, the service did not always receive the full amount of the medicines, in relation to nutritional supplements in particular. As a

result, there were occasions when a person's medicines ran out and the service had to wait for a new prescription and delivery, which resulted in people not having their medicines as prescribed..

When medicines details were handwritten on the medicines administration record (MAR) they were not always signed by two people to indicate they had been checked for accuracy of transcription. There were also some gaps in the administration record for some people indicating the medicine had either not been given or the staff had not signed for the administration. This meant there was an increased risk a person might be given their medicines twice. We checked the balance of two medicines when there was a gap in the administration record and the balance indicated the medicines had not been given. This meant we could not be sure people were receiving their medicines as prescribed. We found inconsistency in the use of codes to indicate why medicines had not been given and the legibility was poor making it difficult to be certain why they had not been given. We saw the room used to store nutritional supplements and the medicines refrigerator was untidy and required cleaning. There were boxes stored on the floor which was littered with debris.

Other areas of the medicines systems were safe, such as the storage and management of controlled drugs, which were checked twice daily at the shift changes. Controlled drugs are a group of medicines that require an enhanced level of secure storage. For this reason, the handling of these medicines is subject to certain controls set out in law. We checked the balance of two controlled medicines and found they corresponded with the amount recorded in the controlled medicines register. Most liquid medicines were labelled with the date of opening and the temperature of the room used to store medicines and the room used to store nutritional supplements were recorded on most days. When people were receiving medicines which required their blood levels to be monitored we saw this was being undertaken and the dosages adjusted according to the directions. Staff had competency assessments prior to administering medicines at the service and completed medicines administration training.

People felt safe and protected in the service. All of the people we spoke with told us they felt safe. One person told us, "I do feel safe; the staff make me feel safe." Another said, "There's no place like home. But I do feel safe here." The relatives we spoke with also said they felt their relations were safe in the service with one saying, "When my [relation] first came here I would arrive unannounced so I could watch their care. I have never seen anything amiss. I am very grateful for this place and the care is really good."

People were supported by staff who recognised the signs of potential abuse and how to protect people from harm. Although records showed a number of staff had not completed a refresher in safeguarding adults from abuse, the staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm and to escalate concerns to the unit manager or to external organisations such as the local authority. Staff were confident that any concerns they raised with the unit manager would be dealt with straight away. The unit manager told us that staff were tested on their knowledge of safeguarding at staff meetings and if there were any gaps in knowledge further training would be explored. One nursing member of staff described an occasion when they had made a referral following an incident in the service and they had a good knowledge of when this action was needed. We saw there was information displayed in the service giving staff guidance on what they should do if they suspected abuse.

The unit manager had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the registered manager carried out checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions. Staff records indicated and staff confirmed they had completed an application form and attended an interview prior to their appointment. One staff record we viewed contained only one reference from a former

employer although the other two records examined indicated two references had been obtained. Professional registration had been checked for one nurse but for another the unit manager had relied on the document provided by the member of staff. The unit manager sent evidence that these issues had been rectified following our visit.

We saw that where people had been assessed as being at risk of developing a pressure ulcer there was equipment in place such as pressure relieving mattresses and we saw these were functioning correctly. The equipment required to support people to move safely was in place and clearly identified in individual handling profiles. We saw occupational therapy assessments had been completed and specialist wheelchairs obtained when these were required for people.

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. We found the service was not working within the principles of the MCA.

People were not always supported to make decisions on a day to day basis. We observed people decided how and where they spent their time and where people had the capacity to make some decisions they had signed consent forms for areas of care, such as the use of bedrails and wheelchair lap straps. However one person we spoke with appeared to have the capacity to understand the risks in relation to an aspect of their care and yet their wishes were not being taken into consideration and staff were supporting them in a way they were resistant to. We asked the person if they had spoken with anyone about this and they told us, "What is the point. They've (staff) made their mind up." We spoke with the unit manager about this person's circumstances and advised they hold a meeting with professionals involved in the person's care to ascertain the level of risk in relation to this aspect of the person's care and agree a way forward with the person to ensure their rights to make decisions were respected, balanced with the risk.

We found the principals of the MCA were not being applied consistently to ensure people's rights were protected. The unit manager and staff we spoke with had an understanding of the Act; however people's capacity was not always assessed to ensure decisions were made in their best interests. For example in the care plans of two people we saw there were consent forms in place for the use of bedrails and wheelchair lap belts, one of these was signed by a relative but the relative did not have the legal authority to make decisions for this person. The other was signed by a member of staff on behalf of the person. Information about both of these people indicated they would not have the capacity to make such decisions, but a formal assessment of their capacity had not been undertaken, and there was a lack of best interest decision making for these decisions.

Staff told us about another person who often refused some elements of their care and as they had the capacity to make decisions in relation to this, staff accepted their decisions. However, their refusals were not documented. Another member of staff said they felt the person may not be absorbing the information they were given and were not sure if the person understood the implications of their refusals to be supported with their care. Staff had not followed the MCA and completed an assessment to assess if the person had the capacity to understand decisions about their care and support and to ensure they were supported in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one person had been supported appropriately under the MCA. The person had completed an advanced decision to refuse treatment as they did not want to receive enthral (PEG) food and fluids when

they were unable to eat and drink normally. A mental capacity assessment had been undertaken to ensure the person had capacity to make the decision and their end of life care plan made their wishes clear. Staff told us they were aware that if a person had an order in place which stated the person did not wish to be resuscitated if their heart failed then a mental capacity assessment and best interest decision should be completed and they had asked the GP to do this for those people requiring it.

People were supported by staff who did not always have the skills and knowledge needed to carry out their role safely. One person we spoke with expressed concerns about an area of staff training. They described an occasion when they had needed support to move to a chair and told us that the staff available were unable to help as they had said they did not have sufficient training to do so.

The unit manager told us that a number of training courses were completed by staff using e learning, which staff generally completed at home. The provider told us they took a blended approach to training with e learning being only one component to the overall training and development provided for. They told us they also provided face to face classroom training with theory and practical training as well as practical on the job training with supervised practice. However, we found there was a lack of system in place to monitor the e learning training staff were completing at home to ensure they kept this up to date and to measure if the training had been effective in giving them the skills and knowledge they needed to do their job. There was an overview of the training staff had completed in relation to percentages but there was nothing to alert the unit manager if staff were not completing the training as planned. We looked at the training figures and saw that there were a number of staff who had lapsed in areas of training. For example, 32% of staff had not completed safeguarding training and 22 % had not completed the infection control training.

When staff first started working in the service they were given an induction and the opportunity to shadow more experienced members of staff prior to delivering care and support to people themselves. The unit manager told us that if staff did not already have a recognised qualification in health and social care when they were first appointed then they were enabled to start this qualification soon after they were recruited. We spoke with a member of staff who had been working in the service for two months on the day we visited and they confirmed they had been enrolled on the course to complete the recognised qualification after four weeks of working in the service. Another newly appointed member of staff told us an induction and training had been booked for them and we saw from staff personnel records for three members of staff that they had been provided with an induction programme.

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 whether any conditions on authorisations to deprive a person of their liberty were being met. The unit manager had made applications for DoLS where appropriate. For example, three people had been assessed as not being able to leave the service without continuous support from staff and so were not free to leave the service alone. There was an up to date DoLS authorisation in place for each person.

We received mixed views about the quality of the food. Some people told us the quality of the food was not good with one person saying, "The food leaves much to be desired." Whilst some people told us they enjoyed the food with another person saying, "It is very good, I enjoyed it today." On the day we visited we saw there were two different options of the main meal given to people, and some people had requested a special order such as an omelette and this was catered for. Staff were available to give people support with their meal where they needed it.

People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. We saw people were weighed monthly and records showed people were not losing weight. Dietetic input had been sought where there were concerns about a person's eating and drinking. One person who was receiving enteral nutrition (PEG) had clear directions in their care plan in relation to their nutrition regime and the care and management of the tube and site. We spoke with the cook and they had a good knowledge of people's food likes and dislikes and knew which people required a special diet.

People were supported with their day to day healthcare. People we spoke with told us they felt they were supported with their healthcare and had access to their GP with one person saying, "He (GP) was here last Sunday." Records showed people were supported to attend regular appointments to get their health checked. There were records showing people saw the dentist, optician and chiropodist on a regular basis and when people were ill they were supported to see their GP. We saw one GP had given positive feedback to the service stating, 'The teamwork between the senior nurses makes the unit a delight to work with. (Staff) have an excellent and expert understanding at nursing level of the complex conditions their clients face.'

Staff sought advice from external professionals when people's health and support needs changed and involved a range of health professionals in peoples care such as physiotherapists and occupational therapists. The provider employed staff to work within different locations they owned in the group to support people with health care such as a Speech and Language therapist. This had been accessed recently when one person had been on a waiting list to see the Speech and Language Team (SALT) run by the NHS for a period of time and so had been assessed and supported by the therapist employed by the provider.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the service and some descried staff as being like their friends. One person said, "I am happy. I like it here." Another person said, "[Staff have] always been great with me." One relative we spoke with said, "I can't fault the staff here at all. They have lifted a huge weight off me. Staff here are sympathetic and brilliant with [relation]."

We observed some very positive interactions between staff and the people who used the service. Staff were knowledgeable about the people they cared for and showed empathy for them. Staff responded to people's needs and took time to understand their non-verbal communication. For example, we observed one person who was restless during our lunch observations and a member of staff responded to this quickly and gave the person reassurance which resulted in them becoming more settled. The unit manager and staff we spoke with showed a passion and commitment towards the people they were supporting.

People we spoke with told us they got to make choices for example about when and where they ate and how they spent their time. We observed people's choices were respected on the day of our visit, for example the care plan of one person stated the person liked to spend time in a small kitchen designed for people in a wheelchair to use and we observed this person spending time there. People who used the service described regular meetings they attended, which were chaired by different people who used the service. They told us they discussed what they would like changing, what was happening in the service and introduced to new staff. People told us that staff were receptive to wishes expressed at these meetings. We saw that during meetings held for people who used the service they were given the opportunity to have a say in future activities and menus and records showed that people were encouraged to speak up if they wanted any changes to be made. We saw in people's care plans that their preferences for how they were supported were recorded, along with their likes, dislikes and what was important to them.

People had opportunities to follow their cultural and religious beliefs. Some people, who chose to, were supported to go to their preferred places of worship on a weekly basis. One person told us, "I go to church every Sunday." We saw the care plan of one person who had specific needs around their culture and we saw the plan contained details of how the person preferred to follow their culture and how staff should support this. We spoke with the cook and they described an example of where they had worked to ensure another person's culture was being planned for in relation to their diet.

We spoke to the unit manager about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. The unit manager told us no one in the home was using this service. Records showed people had been supported to access these services in the past.

People were supported to have their privacy and were treated with dignity. People we spoke with told us they felt staff were respectful. We observed people's privacy was respected during our visit with staff knocking on people's bedroom doors and waiting for an answer prior to entering. Staff were mindful not to have discussions about anyone in front of other people and they spoke with people showing respect.

Staff told us they were given training in privacy and dignity values. The unit manager told us there was not currently a dignity champion as the member of staff who was assigned this role was on maternity leave and the role had not been assigned to anyone else. However the staff we spoke with showed they understood the values in relation to respecting privacy and dignity. We saw that staff were reminded about the values of people's rights to privacy and dignity during handovers and staff meetings.

Requires Improvement

Is the service responsive?

Our findings

People's care was not planned in line with their current needs and preferences. Some of the care plans we viewed contained out of date and inconsistent information about the needs of people who used the service. An initial admission assessment had been completed and a range of care plans were in place for each person to provide information on the person's care and support needs. The plans generally contained a good level of detail about the person's needs and preferences in relation to their care. However they were not always up to date and reflective of the advice given by external professionals or the changes made to accommodate the person's choices.

For example, the recommendations made as a result of a safeguarding investigation into the care of one person, stated they should be checked hourly and at each check the person was to be asked if they needed the toilet and assess if their incontinent aid needed changing. It was stated that all care provided and refusals should be documented. However, we saw the person's care plan contained information which conflicted with the recommendation and in addition there was a notice in the nurse's office which contained further conflicting information Staff provided an explanation for this however this had not been included in the person's care plan to explain why the recommendation was not complied with. Additionally it was stated in the care plan the amount of time the person should be out of bed, but staff told us this was not adhered to. This meant the person's care plan did not describe how the person should be supported in line with their wishes and needs. Each person had a named nurse who was responsible for overseeing their care and we saw the named nurse for this person was the previous manager, who no longer worked at the service.

There were a lot of inconsistencies in the information about two people's dietary requirements within different parts of their care plans and we found this had an impact on the care people received. One person we spoke with told us about issues with staff being unaware of their specific condition which led to confusion regarding what sort of diet they should be on. We saw that another person had a PEG and it was difficult to identify whether they continued to eat food orally as well and if they should be provided with a soft or pureed diet as the information was inconsistent in different areas of their care plan. This put the person at risk of receiving their nutriution in a manner that could cause them harm.

Care plans did not always reflect the advice given by other professionals who had had an input into people's care. For example, a person had been reviewed by the community occupational therapy service and they had asked the service to update the person's moving and handling plan to add information about re-positioning when the person slipped down in their chair, but this had not occurred. Thefore any staff referring to the plan for guidance would not know how to provide the person with the recommended support.

Another person had been assessed as being at high risk of choking and aspirating fluids by the speech and language assessor employed by the provider. There were care plans in place detailing the person should be given a 'mashed diet' and that a thickening agent should be added to their drinks to reduce the risks. However a senior member of staff told us this person was now on a pureed diet and no longer needed the

thickening agent in their drinks. We saw at the rear of the person's care plan an entry from the SALT assessor that the person had been assessed and their diet changed, however the care plans in relation to the person's diet had not been updated to reflect this. We asked staff to confirm what they were giving the person and they told us that thickener was still being added to the person's drinks. This showed the inconsistencies in relation to this person's diet led to them not receiving the diet that was recommended they should.

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

Records showed that some people had been involved in making decisions about their care plan when they first moved into the service and people and their relatives had signed to say they were happy with the plan. However reviews and amendments of care plans were not discussed with people or their significant others. One person told us they knew their care plan had been recently revised but was unaware as to what had been amended. Two relatives we spoke with told us they were aware of care plans in place for their relations (who both lacked the capacity to be involved in their care plans) but had not been asked to be involved in reviewing them.

We observed and were told about inconsistent levels of activity and engagement provided to people who used the service. We saw a group of people were engaged in painting activities in the activities room in the afternoon. However, we spent most of the morning and sometime in the afternoon observing the people in the lounge. They were positioned in a semi-circle around the television, but there was no attempt to engage them in any activities tailored to their needs.

We saw there was an activities schedule in place for the week and this would keep people who enjoyed playing bingo and colouring busy and active. Every week students from a local college attended the service to teach a life skills class to some people, and this was aimed at people with a severe neurological illness or injury. However there was a lack of stimulation for people who would not enjoy this sort of activity and had the capacity to take part in alternative activities linked to their hobbies and interests. One person told us, "I don't get involved with the activities here, they don't appeal to me." Another person told us, "If I wasn't able to take myself out I'd be very bored." A third person told us they went to a place of worship each Sunday and when we asked what they got to do during the week they told us, "Erm.. Nothing."

Although the activity organiser was able to provide evidence of a number of people being supported to go out into the community on several occasion through the year, people we spoke with told us they didn't feel they had the opportunity to do out into the community often enough. One person said, "I'd like to go out more." Another said, "We don't go out very much. I'd like to go in the garden more. It's a mess out there." A third person described their love of the outdoors and being in the garden and told us, "I haven't been out since last year." We saw that people who used the service had made requests in the spring to be supported to go outdoors more.

There were two activity organisers employed by the service and one of these was currently doing an apprenticeship in activities. One activity organiser told us that there had been a lack of people going out into the community from February until June, apart from to the local shops due to a lack of mini bus drivers. They told us that they were now trained to drive the minibus. They told us that a number of people were restricted when it came to be taken out, due to either only having indoor wheelchairs, needing medication to be administered, requiring a particular diets and also the length of time they were allowed to be up in their chairs. This meant that people who had a high level of need were not being enabled to access the community.

We looked at how activities were planned for people and it was evident they were not planned around the individual hobbies and interests of people. The activities organiser we spoke with did not have any written information about people's past hobbies or interests and told us, "When a resident first comes in we ask them what they like to do." However they did not document this.

The activities organisers arranged parties for specific themes and times of the year such as Halloween and Christmas and people's relatives were also invited to these events. There had been some visiting entertainers and events such as a summer fete, a music tribute band and a firework display. People told us they enjoyed these occasions where they were able to socialise and celebrate occasions.

People knew what to do if they had any concerns. The people and relatives we spoke with told us they would speak to the unit manager if they had a problem or concern. They told us they felt they would be listened to. One person told us, "I would feel comfortable talking to the manager if I have concerns but I haven't had to." One relative told us, "Changes are always made if I raise concerns. Staff are receptive and ready to listen." Records showed that during meetings held for people who used the service people were reminded about their right to raise concerns.

The unit manager told us they had received one complaint since we last inspected the service and this, in line with the organisations policy, was being investigated at head office level. The unit manager displayed an understanding of the need to ensure the complaints policy was adhered to and complaints were taken seriously and acted on. Staff we spoke with were aware of how to respond to complaints and there was a complaints procedure in the service so that people would know how to escalate their concerns if they needed to.

Requires Improvement

Is the service well-led?

Our findings

Since we last inspected the service the registered manager had left in August 2016 and there was no registered manager in post. Prior to our inspection the area manager, acting on behalf of the provider told us they had promoted a qualified nurse to be a unit manager, however they had not applied to register with us at the time we visited.

People who used the service and their relatives consistently spoke positively about the unit manager, although one person who used the service told us they were concerned about the levels of management available. The unit manager continued to work as a nurse in the service on set days and also to cover nurse absences, which left less time for the unit manager to get to grips with the running and monitoring the quality of the service. The unit manager had limited knowledge and experience in relation to meeting regulations in health and social care and had failed to notify us of some significant events in the service. There was a lack of oversight from the provider to ensure the notifications were sent, whilst the unit manager was in the transition period of gaining knowledge about the running of the service.

The unit manager told us the area management team employed by the provider had been very supportive and attended the service frequently to give advice. However we observed during our visit that the unit manager was under pressure with requests made by staff and frequent interruptions which would have an impact on the unit manager's time spent undertaking the tasks required of managing the service.

The provider had not taken steps to ensure there was an effective system in place to monitor and assess the quality of the service to ensure issues were identified and necessary improvements made. The unit manager was in the process of trying to implement governance systems designed to monitor the quality of the service and to make improvements where needed. The unit manager had not had a handover of audits which were previously used in the service and so was having to implement new audits where needed. We found that these were not yet effective and this had an impact on the quality of the service deteriorating. The unit manager told us they did not carry out formal care plan audits but they asked nursing staff to complete a check of care plans and provided a copy of the results. However we found care plans were not effective in ensuring staff had up to date information on how to meet people's needs. There were also monthly medicines audits which had been completed and action was taken to address any issues identified. However, the issues we identified during our visit remained unresolved. This showed the audits were not effective in improving the safety of medicines management.

We asked about any analysis of falls and pressure ulcers to see if they led to learning and improvements in the care provided. We were told there had been no recent pressure ulcers except those present on admission to the unit, which had healed. In relation to falls we were told each fall was entered into an electronic incident reporting system used by the provider and there was an investigation of each fall which identified any actions for the person, but there was no analysis of themes or trends to assess if any changes were needed in the service. We had concerns about the consistent reporting of incidents as when we looked at the records of one person, we found they had been admitted to the hospital with a fractured wrist

following a fall. This was not reported on the electronic incident reporting system and there was no information about the fracture or how it had occurred. This meant the system was not being used as intended as not all information was being added.

We saw there had been a health and safety audit carried out by a representative of the provider in September 2016 and this had identified a shortfall in the monthly maintenance checks on bedrails. At the time of our visit these checks were still not being carried out as stated in the provider's policy.

Prior to our inspection there had been some concerns raised about the practice of some staff at night time. This had been investigated by the regional manager and the concerns acted on. The unit manager told us they now carried out visits at night to check staff practice and ensure people were being supported appropriately. However the visits or what the unit manager observed during these visits were not being recorded. This meant there was no evidence of these visits and if there were any concerns identified or what had been done to address them.

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

During our visit we saw evidence that two people had sustained a fracture following a fall and the unit manager had failed to notify us of these. We saw from the records of two people that they had been granted a DoLS by the local authority and the unit manager had failed to notify us of these. The unit manager told us they were unaware that these notifications needed to be sent to us. The failure to submit the notifications had not been identified by the registered provider and these notifications are a legal requirement.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009:

People and relatives we spoke with told us that they were happy with the service received and one relative described raising money specifically for the company because they were so pleased with the care their relative had received. We observed the unit manager interacting with people who used the service and it was evident the unit manager had a positive relationship with people and knew them well. It was clear people felt comfortable with the unit manager and when we spoke with people and relatives they knew who the unit manager was and described having positive relationships.

The unit manager spent time with staff offering guidance and support and we observed staff felt able to approach the unit manager with any issues they had. The staff we spoke with were enthusiastic about working in the service and said they enjoyed the role and some had years of experience working in a care setting. Staff told us the unit manager was supportive and approachable. Records showed that regular meetings were held for staff in relation to their designation such as catering meetings, nurse meetings and care staff meetings. The records showed the meetings were used to remind staff of good practice, update them on any changes and seek suggestions for improvements. One member of staff told us they felt able to raise issues and concerns and said the unit manager addressed these. They gave an example of an issue they had raised which the unit manager had then covered in a staff meeting.

Records showed that an infection control audit had been carried out by external health professionals and we saw steps were being taken to implement the actions identified from the audit. The unit manager told us that the head of housekeeping from their sister service had been asked to undertake an audit of the catering in the service three times a year. We saw one of these audits had already been carried out and as a result a kitchen assistant had been employed and new menus introduced. A health and safety audit had also been completed in October 2016 and improvement actions identified. There was an action plan in place and we

saw evidence that the unit manager was acting on the issues identified, such as a lapse in maintenance of equipment in the service.

People who used the service were given the opportunity to have a say about the quality of the service via regular meetings which were chaired by people who used the service. We saw the minutes of the last two meetings and saw people had been given the opportunity to have their say and make suggestions for improvement. We saw that feedback forms had recently been sent to people who used the service and their relatives to gain their views of the service. The unit manager told us the results of these would be analysed and shared with people and an action plan would be put in place to address any concerns raised.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC of significant incidents in the service. Regulation 18 (1)(2)(a)(iii)(4A)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the MCA 2005. regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring care and treatment was provided in a safe way for service users. Regulation 12 (1)(2)(a)(b)(e)(g)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems to monitor and assess the quality of the service were not effective and were not bringing about improvements. Regulation 17 (1)(2)(a)(b)(c)