Caretech Community Services (No.2) Limited

May Lodge

Inspection report

Barrow Hill
Sellindge
Ashford
Kent
TN25 6JG

Tel: 01303813926

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 10 February 2016. May Lodge was an existing service that closed for refurbishment and people living there moved on. There was a period of dormancy whilst refurbishment works were carried out to provide up to six people with ensuite bedrooms. The service reopened 11 December 2015 on admission of the only and current service user. The new service was set up for people with learning disabilities or autistic spectrum disorder with additional physical disability needs. The service is fully accessible for people in wheelchairs and off street parking is available. At the time of our inspection one person was living at the service and there were five vacancies.

This service was last inspected in September 2013 when we found the provider was meeting all the requirements of the legislation.

At this inspection there was not a registered manager in post: the previous manager ceased to be the registered manager for the service from 11 December 2015. Interim management cover arrangements from within the organisation had lacked continuity and been ineffective. 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.

There had been a lack of preparation for the opening of the service and the support of the only person currently admitted. The person accommodated could be placed at risk because although staff had received their basic essential training to undertake their role, they had not received additional specialist training in regard to the person's method of communication, their moving and handling needs. Staff had been provided with training to support people whose behaviour could be challenging, but, an individual behaviour management strategy had not been developed and implemented for the service user to ensure support around behaviour was consistent.

Risks were not appropriately assessed or measures implemented to protect the health and safety of the person or staff. Some checks and tests of the fire alarm and equipment were not undertaken and new staff had not participated in a fire drill in the new premises. Accidents and incidents were recorded by staff but not analysed by senior staff or managers to assess whether measures implemented were effective or needed amending. The persons health care needs were not appropriately assessed with detailed support plans around this in place.

Staff showed that they understood the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLS), but the provider and senior staff had not ensured that capacity assessments had been completed or a DoLS authorisation reviewed and updated.

A detailed care plan to provide staff with a step by step guide to the support the person required to meet their needs had not been developed, and staff were not recording changes that they became aware of to

inform the plan of care.

A complaints procedure was not displayed and information including the complaints procedure was not in suitable formats for the person supported to understand and make use of. Staff were working to out of date policies and procedures. In the absence of formal staff meetings and management support staff were holding their own informal meetings to seek support for each other around the operation of the service and the delivery of care to the person. A system had not been established yet for the assessment and monitoring of service quality through a series of audits.

There were enough staff to support the person but they lacked all the competencies they needed to support the person safely. Seventy five percent of staff support was provided by agency staff block booking by the provider assured that a continuity of staff support was provided to the person. Agency and permanent care staff were provided with induction to their role but this was not sufficient to meet all the person's needs.

The person was provided with space to spend time on their own. They had been supported to personalise their bedroom with small possessions and photographs and supported to maintain contact with their family. There was a lack of structure to the person's week but staff provided them with some opportunities to go out and to attend activities; they were guided by the person about when this happened. The service was clean and well maintained.

In the absence of a registered manager interim arrangements for the oversight of this service were inadequate with inconsistent and infrequent support provided by a senior manager not based at the service. No audits to assess and monitor the quality of the service had been established.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks were not adequately assessed and mitigated for. Accidents and incidents were not analysed to see if these could be reduced.

There were enough staff but they did not have all the right competencies to meet the person's needs. Some fire safety checks and tests were not being undertaken. Staff recruitment records did not contain all required information.

Medicines did not need to be administered by staff, and they were not trained to do so. The premises were clean and well maintained; staff understood how to protect people from abuse.

Is the service effective?

Inadequate

The service was not effective.

Staff were trained but had not received some important specialist training to deliver support in accordance with the person's needs.

Staff understood the principles of the Mental Capacity Act 2005 but managers had not ensured that capacity assessments were completed or a Deprivation of Liberty Authorisation reviewed and updated.

The person's health care needs were not appropriately assessed and supported. Care staff and agency staff received induction to their role in the service, but this was not effective to meet the person's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff respected the person's privacy and dignity. However, staff did not always engage with the person because they were not confident about supporting them with behaviour that may be challenging. There was a risk that the person was isolated at

times.

The person was provided with space to spend time on their own and routines were relaxed but their potential for independence was not assessed.

The person had been enabled to personalise their room with small possessions and photographs.

The person was supported by staff to maintain links with their family.

Is the service responsive?

Inadequate

The service was not responsive.

An updated care plan was not in place and changes or knowledge that staff gained about the person was not being recorded to inform care plan development.

A complaints procedure was not displayed; an accessible version was not available for the person supported.

Staff provided opportunities for the person to go out and were guided by the person about when this happened, but there was a lack of structure to the person's week and no schedule for regular activities and outings.

Is the service well-led?

Inadequate

The service was not well led

In the absence of a registered manager, interim management arrangements were infrequent and failed to provide staff with adequate oversight, supervision and guidance.

Policies and procedures accessible to staff were out of date. Formal staff meetings were not held. Health and safety risks were not appropriately assessed and monitored.

No audits were undertaken to assess, monitor and improve the delivery of service quality.

May Lodge

Detailed findings

Background to this inspection

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

This inspection took place on the 10 February 2016 and was unannounced. The inspection team consisted of one inspector.

This was not a new service but it had been empty for some time whilst undergoing extensive refurbishment before new people were admitted and new staff employed, the provider had not been sent a Provider Information Return (PIR) prior to the inspection for this reason as there had been no regulated activity there and because the Care Quality Commission had only just been made aware that the service was now open. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked to see if we held any other information about the service that could inform our inspection; this would usually include previous reports, complaints and notifications. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

There was only one person residing at the service when we visited who we met. They were in their bedroom for the duration of our visit and was unable to speak with us directly about their views of the service, because they would have found our presence in their bedroom intrusive we were unable to use other methods for example the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We requested details of relatives and a care manager so we could seek their views about the service but these had not been provided by the service. We spoke with the only employed member of staff and an agency staff member during the inspection and we also spoke with a deputy manager from the sister home May Morning next door who provided limited oversight of some aspects of the service.

We looked at the care records held for the person including care and support plans, risk assessments,

activity planners, and a health record. No medicines were administered at present so systems for managing this were not in place. We looked at menus and operational records for the service including: staff recruitment, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

There was only one person living in the service at inspection. They had been admitted as an emergency and the service had not been fully prepared to support their specific care and support needs; because of this they could be placed at risk of harm. The person was unable to tell us about their experience of care.

Some important risk information was not available or had not been updated for the person supported to reflect their change of environment and whether the same risks existed. Individual and environmental risks had not been adequately assessed to ensure that risk reduction measures were in place and were appropriate for them. For example the person had fallen from their wheelchair on two occasions since admission, a falls risk assessment had not been developed to highlight this risk to staff or to make clear the risk reduction measures needed to maintain the persons safety. A moving and handling assessment had also not been completed to inform how the person needed to be moved by how many staff and what equipment should be used. As a consequence staff admitted they had lifted the person back into their wheelchair on both occasions using an illegal underarm lift; this type of lift is no longer acceptable or seen as good practice because it could cause injury to the person concerned and to staff. No hoist was available for staff to use to help with lifting the person and staff said they had not received training to use a hoist if one was provided.

Accidents and incidents were reported by staff but a system had not been established by the provider or senior staff to routinely analyse those accidents or incidents occurring and to develop strategies to guide and inform staff support. Accidents recording the falls experienced by the person had not prompted a review of their moving and handling or falls risks and whether this needed to be supported with equipment to minimise potential injury to the person and staff.

Additionally, we understood there was a potential risk of property damage from the person supported and risks associated with this, for example electrocution as the person supported had damaged light switches and needed monitoring around this; a risk assessment had not been developed to inform staff how to manage this safely. There was a failure to ensure that risks from events, the environment or risks people may experience in their everyday care had been appropriately assessed and measures had not been implemented to reduce the level of risks. This is a breach of Regulation 12 (2) (a) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The person could be placed at risk because weekly and monthly visual checks and tests of the fire alarm and fire equipment were not being carried out; no fire drill had been held to ensure the new staff team were all familiar with the action they needed to take in the event of a fire. A fire risk assessment was in place but staff were not adhering to the frequencies of equipment tests or checks or drills recorded within this information. An individualised personal emergency evacuation plan was in place for the person supported but this related to their previous placement; this had not been updated to reflect any changes which may need to be considered in this placement. Staff were provided with emergency contact numbers in the event of a stoppage to the water, or electrics, but they were unaware of a business continuity plan for other events that could impact on the service, for example heavy snow and the ability of staff to get in for shifts. There was a

failure to ensure that risks of fire and other events that stopped the service had been adequately mitigated. This is a breach of Regulation 12 (2) (a) (b) (d) of the Health and Social care Act 2008 (Regulated activities) Regulations 2014.

We were able to confirm with the staff present that they had received updated fire training prior to working in this service and were aware of the fire evacuation procedure and where they should assemble for safety. The fire alarm and fire extinguishers had been serviced as part of the recent refurbishment. The premises provided a comfortable modern environment for people to live in, and staff were able to show that minor maintenance works were reported and addressed in a timely way. The main electrical installation had been serviced at the time of refurbishment, and no gas was used.

The premises was clean and tidy with most areas unused other than the person's ensuite bedroom, the kitchen, dining room and lounge area. Staff on duty were observed undertaking some cleaning activities for example mopping floors and wiping down surfaces but this was largely an informal arrangement established by the permanent staff member. There were no systems established to ensure that routine and more in depth cleaning tasks were scheduled. At present this was not an issue but with an influx of people to the service this will need to be addressed and is an area for improvement.

There was no established system in place for the management of medicines. None of the staff team had been trained to administer medicines. This was not an issue most of the time because the person supported was not prescribed routine medication; however, they were subject to intermittent infection that required prescribed medicines which none of the present team would be able to administer. We were advised that in the event that this happened a trained staff member from the sister home next door would be called in to provide this support until a more established team was in place and they had been trained in medicines management. This is an area for improvement.

There were enough staff on duty but they did not have the skills and competencies they needed to fully meet the person's needs because they had not been trained in British Sign Language (BSL) the persons form of communication and had not received appropriate moving and handling training to ensure this was managed safely, and three out of four staff all of whom were from an agency had not received training in the preferred behaviour management interventions used by the provider in their services. No rota had been developed; this was because the same four staff were responsible for covering every shift between them. The person was supported by two staff on every shift, with one waking night staff member and one sleep in staff member. There was currently one permanent staff member who had only one years' experience of care, they were supported by three agency staff who had been block booked by the provider to give some continuity to the support offered to the person. No other staff were involved in the persons support. The permanent staff member worked 7:30 AM to 9:30PM Monday to Friday; all other shifts were covered by agency staff.

There was a failure to ensure that staff had been provided with the necessary training skills and competencies appropriate to meet the needs of the person they were supporting and this could place the person at risk of receiving poor quality care. This is a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was only one permanent staff member currently employed in a team of four care workers supporting the person. The staff member's recruitment file showed all required checks had been carried out prior to their employment including two conduct in employment and character references, evidence of personal identity and a criminal records check through the Disclosure and Barring service (DBS), there was an application form with an employment history and there was a health statement regarding their fitness to

undertake their role.

Staff did not have access to the policy and procedure regarding safeguarding adults. People were protected from potential abuse however, because staff had received safeguarding training that helped them to understand, recognise and respond to abuse. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to the locality manager or the provider or to outside agencies where necessary. They had been provided with contact numbers if they needed to speak with senior staff urgently.

Inadequate

Is the service effective?

Our findings

The person supported could be placed at risk because staff did not have all the skills necessary to provide him with the specialist support he required, for example the person communicated well using British Sign Language (BSL). The communication passport transferred from their previous placement made clear this was pivotal to their being able to engage with those around them effectively. None of the staff currently supporting the person had received BSL training and this hampered their ability to converse with the person, develop a relationship and enable the person to be involved in decisions about their care and support. There were no plans to ensure staff received training in using BSL. One member of staff had been booked to attend a Makaton course (this is a language programme using signs and symbols to help people communicate); however, the person did not use this sign language and would not benefit from the staff receiving this training. There was a failure to enable and support the person by means of effective communication to make or participate in making decisions relating to their care and treatment this is a breach of Regulation 9 (3) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Similarly staff had received moving and handling training but had not been trained to use a hoist, which was needed on occasion to help the person when they had fallen from their wheelchair. Sometimes the person supported experienced episodes of anxiety that led to their behaviour becoming challenging for staff or others. Staff had been trained in conflict management and physical intervention, but no guidance was developed and implemented to inform staff what interventions they should be using to manage behaviour, this posed a risk that interventions may be inappropriate or inconsistent. No system was in place to debrief staff about interventions used and whether the strategies they used for behaviour management needed to be adjusted accordingly to be more effective.

At the time of inspection the staff team were unaware if the person had been registered with a GP; they were without any GP contact details in the event of the person becoming unwell. We were able to establish that the person had been registered with a GP nearly two months after being admitted to the service but this information had not been made known to the staff team, and was not recorded in the person's health support information. A health action plan had transferred with the person from a previous placement but this had not been updated to reflect new health contacts.

The person's physical disabilities required that they had regular exercises but these were not documented to ensure all staff provided these consistently, for the same length of time, and the same exercises. The permanent staff member thought that the person had gained in weight since coming to live at the service, a nutritional risk assessment had not been completed to highlight if weight gain was an issue, and there were no chair scales available to check how much weight the person had put on. Staff said the person ate most things and a record of food provided showed this to be varied, but an established menu that ensured a healthy balanced diet was maintained had not been implemented. There was a failure to ensure the person received safe care and treatment and that their health needs were assessed. This is a breach of Regulation 12 (2) (a) (b) (c).

Staff sought consent from the person to everyday support tasks through the use of a limited number of basic

signs they had learned, but they lacked the ability to communicate with the person effectively to carry out more comprehensive capacity assessments. Staff had received Mental Capacity Act 2005 training and understood that where people lacked capacity to make some of the more important decisions for their selves around care and support these decisions could be made on their behalf through best interest discussions. The Mental Capacity Act 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for their selves.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The person had been subject to a DoLS authorisation previously and staff felt this should be maintained but this had not been updated to reflect the change of location and the permanent staff member was unaware who might be dealing with this within the organisation.

The failure to establish systems for the assessment of peoples capacity and to ensure Deprivation of liberty authorisations are reviewed and kept updated is a breach of regulation 11(1) (3) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

The one permanent staff member was unsupported in their role; with no routine oversight form a senior care staff member or a manager within the organisation. They had last received supervision in December 2015 and before they commenced working at this service. Since then there was no evidence of any routine oversight of the staff member or agency staff in how they were carrying out their duties, or their training and development needs to support the person appropriately. Although the permanent staff member showed they had made attempts to build a sense of team with the agency staff present, and they were able to attend staff meetings at the service next door, there was a sense of isolation and an absence of direct support from senior staff.

The permanent member of staff told us that as they had been new to care they had completed a nationally recognised induction programme for staff new to care when they first commenced work with the organisation. Since then all their essential basic training for example, first aid, food hygiene, fire safety, infection control, safeguarding and moving and handling had been updated before they were transferred over to this service. Given the shortfalls we have highlighted in respect of unsafe moving and handling practice, inadequate fire procedures and practice, an absence of cleaning schedules, lack of understanding regarding the link between weight gain and the absence of a healthy eating regime, the basic level of training provided to the staff member was inadequate and ineffective and did not provide assurance that the persons needs were being fully met.

An agency staff member told us that their basic essential training was kept updated by the agency they worked for and that this was all currently in date but this could not be corroborated. They said they had been given an orientation to the service when they commenced working there and had been inducted into the needs of the person supported by being given access to their care records transferred with them from their previous placement. Agency staff supporting this placement had not been provided with training around the use of a hoist and had not been trained in British Sign Language the form of communication used by the person, so they could not communicate effectively.

There was a failure to ensure that staff had been provided with appropriate support, and supervision and the necessary training skills and competencies to meet the needs of the person they were supporting and this could place the person at risk of receiving poor quality care. This is a breach of Regulation 18 (1) (2) (a) of

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

Requires Improvement

Is the service caring?

Our findings

We met the person briefly as we had asked to be introduced to them, we asked if we could come into their bedroom and they signed to us that they were ok and gave thumbs up sign. The person's routines were relaxed and they were eating a late breakfast in bed watching the television. We left after a short while as this was intrusive for them.

The person was relaxed and comfortable with the staff on duty, despite the lack of management oversight and support staff were doing their best for the person they supported. Their attitude towards the person was respectful; they gave them space to decide when they were ready to interact with staff and/or needed support. Staff were observed to respect the person's privacy and dignity and when the person was in their bedroom discreetly checking that they were safe. Owing to the persons hearing impairment staff were mindful of the need to make their presence known to the person when they entered his room, they gave warning of their presence by opening the door slightly and tapping on the wall; the vibration they said was enough to alert the person to their presence. A flashing light was also installed to alert the person to when the fire alarm was sounding.

There was a sense that staff were wary of setting off incidents of behaviour and therefore this meant the person was left alone in their bedroom for long periods of time every day. Daily reports showed that they spent long periods of inactivity in their bedroom watching films on the television. There was little structure to their day, for example daily reports indicated that on some occasions the person had not left their bedroom until 1pm in the afternoon and returned to it at 6 pm.

In discussion staff showed they were developing an awareness of the behaviour and gestures the person used to communicate for example, that they were ready for their meal or for personal support. There was no clear promotion of independence for the person although staff did say that on occasion the person helped to prepare their own lunch; this was not however, recorded as part of their care plan, was not part of an established daily routine and goals to promote this type of independence with staff support were not set for the person to work towards. Staff, engagement was limited by their lack of the training and knowledge pf British Sign Language (BSL), the communication method used by the person.

Information within the service had not been adapted into a format that the person could understand and that would help them feel more involved. Some objects of reference (are objects which have meaning assigned to them, these are usually small pictorial or solid objects that represent an activity or task for the person who would be familiar with them) were used to help the person make choices, and an activity board with pictorial prompts was used to inform the person what they were doing each day. For example, having a shower, going out for a drive or to an activity. The limited vocabulary of signs that staff were able to use to convey some basic information to the person had not been added to their communication passport to help other staff who may provide support at a later date.

Care records provided from a previous placement contained information about the important people in the person's life and important events they might need to be reminded about. They were supported to maintain

their relationship with their family and were supported to make regular contact with them. The person was supported to use Skype when having remote contact with their family. Several home visit dates had also been established.

Inadequate

Is the service responsive?

Our findings

As the person had been admitted as an emergency there had been only a brief opportunity for their parents to visit this location and for a pre-admission assessment to be undertaken, no transitional period was arranged and there was little involvement of the then registered manager in the decision to offer a placement. A copy of the pre-admission information was not made available to staff to help inform them about the persons assessed needs.

Care and support records from the previous placement were provided to the service for staff to reference but these reflected what the person's needs and routines were in a different location and with specific staff they had known for many years. The person had been in this service since 11 December 2015 and a new care plan should have been developed that contained a step by step guide for staff to supporting the person, including their known preferences, what they could do for themselves and what support they required from staff to ensure they received care and support consistently, according to their wishes and that staff promoted their potential for independence in some aspects of their care and support. Staff however, were still reliant on the information provided about the person from their previous placement, staff showed that they were reading this and this had helped initially but from their experiences of working with the person they were not using what they had learned to develop their own plan of support or communicate effectively with the person to involve them in this process.

As part of the support offered it had been identified that when alone in their bedroom the person required monitoring by staff every half hour to ensure they were not at risk of harming themselves through property damage or had not fallen from their wheelchair or the bed. When we asked to see the checks made we were informed these were not recorded, and the permanent staff member acknowledged that no recording system had been established to ensure checks were happening and what staff observed at every check. Without management oversight the importance of these recording checks could be overlooked and the person could be placed at risk. There was a failure to develop and maintain a plan of care and support to reflect the current needs of the person this is a breach of regulation 9 (3) (a-h) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was not displayed and complaints information had not been developed into a format that the person could understand. The permanent staff member who was co-ordinating the service was unaware of any complaint having been received since the service reopened, but any complaint would be alerted to the locality manager who in the absence of a registered manager was having some input into the operation of the service. There was a failure to ensure that information about how to make a complaint was displayed for people to see and was also provided in a format suited to the needs of the person supported. This is a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No care plan regarding the interests and activities the person preferred to do had been developed. Staff on most days completed a daily report that recorded what the person had done that day, their mood and behaviour, what they had eaten, any contacts they had with professionals or family and any incidents that

had occurred. These reports showed that there were opportunities provided for the person to go out when they chose to the cinema, café's, shopping, the local pub, staff used pictorial prompts and objects of reference to involve the person in making decisions about what they wanted to do, staff said they were trying different types of activities to build an understanding of what the person preferred or was interested in.

An activity planner incorporating some of the preferred activities had not been put in place to add structure to the persons week, routines were relaxed and activity decisions were made on a day by day basis often dependent on the persons mood, or other factors for example, the weather.

There were limited facilities nearby for the person to visit; a car had been hired to enable staff to take the person further afield; only two staff of the four staff were able to drive. No clear plan had been put in place to ensure that one staff member on shift was always a driver. Before the person was in the right frame of mind to go out a specific routine had to be completed which staff could not skip without this possibly precipitating anxiety and behaviour from the person supported. Staff were not provided with adequate guidance to help them review this routine in a way that would allow the person to make better use of their day and experience a wider range of activities. There was a failure to provide an adequate and varied range of stimulation to meet the social, physical and mental wellbeing needs of the person supported and this is a breach of Regulation 9 (1) (b) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the time of inspection there was no registered manager in place to oversee this service. Interim management arrangements for the service were not working well. Following refurbishment this service had been reopened hurriedly for the new person without appropriate preparation made to ensure their needs could be fully met or that there was a staffing structure and management oversight in place. Nominal management input was provided from the deputy manager from the sister home next door in respect of checks to petty cash and timesheets each week. The deputy manager informed us that they had no other involvement in the day to day operational management of the service and provided no supervisory support to the staff there. They and staff at the service confirmed that support for staff was being provided by the locality manager, however, when we asked to see dates of when they visited and records of her discussions, we found there were no records for them to refer to and visits had become less frequent. Staff however, were aware that they could contact the locality manager in an emergency or call the out of hours contact number for management support if necessary, but there was a lack of everyday support advice, guidance and general encouragement for staff that they were supporting the person appropriately.

The person effectively in charge of the day to day operation of the service and the monitoring of support was a care worker with only one year's care experience. They along with the agency staff team had not been provided with the training necessary to fully meet the needs of the person placed, in respect of moving and handling, behaviour management, and communication, or provided with the necessary equipment to ensure the safety and wellbeing of the person placed.

Care information had not been developed by senior staff to ensure the staff providing support were informed and guided as to how this should be delivered. Records of changes to care needs noted by care staff or knowledge gained from working with the person was not being recorded to inform and update the care plan or risk information. Risks the person may be subject to in regard to their environment and from their own personal needs had not been assessed and measures implemented to mitigate possible risks.

Although there were safe recruitment practices in place the provider had failed to ensure that records relating to staff met regulatory requirements as photographs of staff had not been kept on their recruitment files. There was a failure to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. Regulation 17 (2) (d) (i)

Operational safety checks and tests were not being completed in respect of fire safety and drills, mental capacity assessments had not been completed and a DoLS authorisation not reviewed and updated.

Policies and procedures within the service were out of date, we understood these could be accessed on line but the permanent staff member who was the only member of the team with a computer login had never been shown how to access them. Staff were therefore without any updated means to reference policy and procedural information to guide their practice and ensure this was in accordance with the requirement of the organisation.

Staff said that accident and incident information would be analysed by senior staff every week, in reality we noted a number of incidents in a tray that covered several weeks and staff confirmed that no one in authority had yet seen them. The lack of regular management oversight and analysis meant that staff were left without guidance as to whether the support they provided to manage incidents of behaviour was effective, or whether alternative strategies needed to be used and what these should be.

Without management support the staff in the service had agreed to meet in informal staff meetings to discuss issues related to the service and also the support they were providing to their only resident. These were informal and not recorded for reference purposes.

Other than checks of the petty cash and staff time sheets no system for the assessment and monitoring of the service had yet been established. No senior staff members within the organisation were conducting monitoring checks to ensure that shortfalls were identified and improvements made. As a result staff were working unsupervised without adequate monitoring by senior staff, records were not maintained. The failure to assess, monitor and supervise the operational day to day management of the service is a breach of Regulation 17 (2) (a-d) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to establish systems for the assessment of people's capacity and to ensure Deprivation of liberty authorisations are reviewed and kept updated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was a failure to ensure that information about how to make a complaint was displayed for people to see and was also provided in a format suited to the needs of the person supported.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a failure to provide an adequate and varied range of stimulation to meet the persons social, physical and mental wellbeing needs. There was a failure to enable and support the person by means of effective communication to make or participate in making decisions relating to their care and treatment. There was a failure to develop and maintain a plan of care and support to reflect the current needs of the person.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure the person's health needs were assessed and appropriately supported and that they received safe care and treatment. There was a failure to ensure that risks from events, the environment or risks people may experience in their everyday care have been appropriately assessed or that measures had been implemented to reduce the level of risk. There was a failure to ensure that risks of fire and other events that stop the service have been adequately mitigated

The enforcement action we took:

warning notice

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. There was a failure to assess, monitor and supervise the operational day to day management of the service.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to provide staff with the appropriate support, supervision and necessary training skills and competencies appropriate to meet the needs of the person they were supporting; this could place the person at risk of receiving poor quality care.

The enforcement action we took:

warning notice