United Response

United Response - 4 Burnham Avenue

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 16 and 18 August 2016.

The service is a residential care home, which provides care and support for up to five people with a learning disability. At the time of our inspection there were five people living at the home.

The service is a detached three-storey building, with an open plan lounge and dining room, which leads into a small conservatory. On the ground floor are a kitchen and two utility rooms leading out to a well-kept garden. There is a downstairs toilet and a bathroom on the first and second floor. The service had a cat, which people told us they liked having around.

The registered manager had officially left the service in August 2016 but had been absent from managing the service in the four months prior to this. The provider had notified us of the registered manager's absence. 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 and associated Regulations about how the service is run. At the time of our inspection, a new manager was on their second day of employment. The provider told us it was their intention to support the new manager to register with the Care Quality Commission without delay. Since July 2016, a new area manager was overseeing the service. The new manager and area manager were present for both days of the inspection.

There was a systemic failure in areas of the service, which led to people being in receipt of poor quality care. The provider had a lack of insight into the previous registered manager's and area manager's failure to follow their processes. This meant that all aspects of the service were failing and people were not always receiving their planned care.

The provider's systems and processes designed to monitor the quality of the service were not always followed. Internal audits and checks did not identify issues, which were affecting people's safety and wellbeing. The response by the provider to any issues that were identified was inadequate and did not improve the service.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into '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.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care.

Medicines were not managed safely. There was no system for checking, the stock of medicines or to monitor the competency of staff responsible for administering medicines. Changes had been made to the prescribing instructions without evidence this was supported by an appropriate healthcare practitioner. The dates of when creams had been opened were not being recorded, this presented a risk because after the expiry date, prescription creams may not be safe or they may lose their effectiveness.

The service did not have appropriate systems in place to protect people from harm. Although most staff had received safeguarding training, this had not been embedded into the culture of the service. This meant staff were unsure of how to report issues of concern.

We found that the service was not clean. There was evidence of poor cleanliness throughout the building. There were no cleaning schedules in place or hand soap to promote infection control and cleanliness. We shared our concerns with Environmental Health.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA); however, this was not always demonstrated when making best interest decisions for people who were deemed to lack capacity. We made a recommendation to refer to the MCA and its codes of practice. Staff demonstrated a good understanding of the Deprivation of Liberty Safeguards (DoLS) and how to put this into practice.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. The staff were not in receipt of appropriate support from the provider to enable them to carry out their duties they were employed to perform.

Prompt referrals to health and social care professionals were not always made in response to changes in people's needs or behaviours.

People spoke fondly about the staff and at times, we observed some positive interactions between staff and

people. However, we found that people's dignity and independence was not always promoted.

There were gaps in some people's care plans, which meant staff, did not always have the information they needed to provide safe and consistent care. People and their relatives were not always involved in planning and reviewing their care. This meant we could not be assured that people's care preferences were being regularly identified and met.

People did not receive person centred care as the care records did not give adequate information required for individualised care. There was a programme of social and leisure based activities on offer to people. However, there was no evidence in how those activities had been chosen and how people had been consulted.

People were reluctant to complain about their care and effective systems were not in place to promptly manage complaints to improve people's care.

The provider did not always notify us of reportable incidents and events as required.

Food was produced using fresh ingredients to a high standard and offered good choice. People could choose to eat in the dining room or other areas of the home. Drinks were provided at regular intervals and on request.

During this inspection, we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's care plans and risk assessments, lacked detail. These documents were not appropriately managed and reviewed. They did not contain sufficient detail to inform staff of risk factors and appropriate responses.

People were not protected from the risk of abuse or improper treatment because the provider had failed to embed the systems, designed to protect people. Therefore, staff did not understand their roles and responsibilities to safeguard people.

People were at risk of harm as there was no system in place to manage people's prescribed medicines safely.

Staff recruitment practices were safe. There was enough staff deployed at the service to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received care from staff that had not received sufficient guidance to implement their knowledge and skills. Staff did not receive adequate support to carry out their roles.

People's health needs were not always effectively monitored and managed and, prompt referrals to health care professionals were not always made when people's needs changed.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were always made in people's best interests; however, the new manager took immediate action to ensure this practice improved.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were followed and people were not being unlawfully deprived of their liberty.

People were provided with a balanced diet and had ready access to food and drinks.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported to receive care and support in a dignified manner.

People's preferences for the way in which they were supported were not suitably met or clearly recorded. Care was centred on people's immediate individual needs, in a re-active and unplanned way.

People were not always involved in making decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

People and their representatives were not always involved in the planning and review of their care.

Care plans did not contain the information staff needed to meet people's individual care needs and preferences.

There was a programme of social and leisure based activities on offer to people. However, there was no evidence in how those activities had been chosen and how people had been consulted.

The service did not have a system to effectively record complaints. Complaints were not always managed effectively.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the management team, which meant that people did not receive a consistent safe and appropriate service.

The service lacked appropriate governance and risk management frameworks, which resulted in poor outcomes for

people who used the service.

People were not able to provide feedback about the quality of the service.

Appropriate notifications had not been made to the CQC.

Records were not properly maintained to ensure that information was available to all staff in an up to date and appropriate format or to show that management of the service were governing effectively across the service.

United Response - 4 Burnham Avenue

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 16 and 18 August 2016 and was unannounced. One inspector undertook the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. 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 the provider is required to send us this by law.

During the inspection, we spoke with five people who were living at the service. We spoke with four members of staff, an acting senior support worker, the newly appointed manager and the area manager. We spoke to one relative. We spent time observing people in the communal living areas.

We looked at the care plans and associated records for three people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records. Following the visit, we also contacted four health care professionals to seek their views. One of which, provided us with feedback, included in this report.

The service was last inspected on 03 July 2014 when no concerns were identified.

Inadequate

Is the service safe?

Our findings

Some people told us they did not feel safe at Barnham Avenue because of the behaviours some people who used the service displayed. One person said, "[person] keeps banging the doors, this upsets me. I don't know why [person] does this, I try and stay in my room". Another person said, "It's normal for [person] to bang things, I just put up with it". Other people told us, "The home is not very clean, it smells horrible. There is never any soap". Another person told us, "There is never any soap to clean our hands; it's been that way for as long as I can remember". Despite some people, telling us they felt unsafe, other people told us they did feel safe. One person told us, "I feel safe; the staff have never hurt me". Another person told us, "Yes I do feel safe, there is plenty of staff".

A relative told us, "Staff look after [person], they understand [person] they understand the things [person] needs and finds difficult. I think [person] is incredibly safe".

Risks to people's safety as a result of people's behaviours were not always assessed and planned for. For example, two people who used the service frequently displayed episodes of verbal and physical aggression towards other people and staff. The risks associated with these behaviours had not been planned and there was lack of guidance for staff to follow. A person who displayed particular behaviours did not have guidance for staff on how to respond to ensure theirs and other people's dignity and privacy were maintained. One care plan said 'if you need to change a routine, change the [communication] board and use my [communication] cards. If you don't sort it out, I might do something more serious.' There was no guidance for staff, on what 'more serious' looks like and how to support the person. Another care plan stated the person had a particular health condition, which makes them prone to bouts of anger, and verbal / physical aggression. There was no guidance for the staff on this condition, and no explanation of how the physical aggression presents, or how to respond. For the same person, the care plan asked staff to refer to another record on their known triggers, on how to support reduce stress, these could not be found. The acting senior support worker confirmed they were not used. For two people, the care plans indicated that staff were to document the behaviours on an Antecedent-Behaviour-Consequence (ABC) Chart. This direct observation tool can be used to collect information about the events that are occurring for a person within an environment. "A" refers to the antecedent, or the event that precedes behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence. There was no evidence that these records had ever been completed. The impact of this means, that people's behaviours were not being regularly reviewed and analysed to ensure the support from staff is the most appropriate.

Staff told us and we observed that they did not know how to manage these behaviours. For example, we observed one person's behaviours escalate over a three-hour period. Staff did not follow best practice techniques to manage this person's behaviour. This resulted in the person becoming increasingly distressed, which placed them, other people and staff at risk of harm to their safety and wellbeing.

Effective and prompt action had not been taken to identify and manage a person's risk of falling relating to their mobility. The person had a syndrome that affected their mobility. There was no care plan in place to provide guidance around this need or how to support the person's decreasing mobility. From April 2016 to

the time of our inspection, the person's daily records documented they were struggling with getting in and out of the bath. The records documented that the person's routine had changed. There was reference to them not wanting to have a bath possibly because they feared a fall. The impact of this meant the person was not always following their routine of washing to maintain good hygiene. These observations had not been reported to anyone in charge and the care plans had not been reviewed and updated to reflect the person required a reassessment of using the bath. The inspector observed that this had affected, the person's personal hygiene, and shared this with the manager at the time of our visit. The person was then supported with their personal care. A support worker recorded in the person's daily notes on 19 July 2016, they recommended the person should be encouraged to use the walk-in shower. We could not see any evidence that action had been taken. This meant people could not be assured that the provider was effectively managing the risk of falls.

In April 2016, a support worker recorded in the daily records that they observed a person choking. The records indicated the person choked on a scone and was quite shaken up. There was no evidence that this was an assessed risk or that the risk had been reviewed following the choking incident. The monthly review did not include it had occurred and there was no evidence of what support was provided at the time or after.

One person on a regular basis urinated in their bedroom sink; staff told us the registered manager, to stop this from happening removed the sink from the person's bedroom in July 2015. Following our inspection, we met with a director for United Response, they told us, the provider was not aware that the sink had been removed. Staff were not able confirm whether health care professional had been referred to for advice. Since July 2015, the person has continued to urinate on the floor in their bedroom, where the sink used to be. There was no assessment conducted to establish why this was happening and no proactive measures put in place to support this behaviour. The impact of this meant the room had a powerful odour and in a state of very poor hygiene. The dampness this had caused had gone through to the person's floorboards; attempts to deep clean the area had been unsuccessful.

We observed that equipment at the home was not effectively checked or maintained to ensure it was safe for use. The fridge containing people's food and medication appeared to contain cat hairs. During both days of our visit, the cat was sat on top of the fridge. The fridge was unclean and was reading a high temperature of 9 degrees. This placed people at risk of acquiring infections or suffering food-borne illnesses if food was not chilled at the correct temperatures. Daily records had not been kept to record the fridge temperature, therefore we were unable to identify if this was an acute or long-term problem. Where a person's sink had been removed, the wall had been left with exposed plaster, stains and the piping had been left, which was a trip hazard. The person whose room this was, had a known mobility issue and was at risk of falls. A bathroom door had a hole in it from where it had been damaged.

The home was not clean and was poorly maintained. There was evidence of poor cleanliness throughout the building, including the majority of the dining chairs that had an unpleasant odour. Carpets were not thoroughly cleaned and soft furnishings were stained and dirty in places. There was a film of dust over skirting boards and other surfaces. Each bathroom was discoloured and dirty. The baths in both bathrooms were stained and chipped. We observed toilets and toilet brushes heavily stained and were rusty. Floors in bathrooms were water stained and in places mouldy. On the second day of our inspection, we observed urine on one of the bathroom floors, of which there was a delay in this being cleaned. The home had a malodour throughout. There were six communal sinks (one in the ground floor toilet, one in the bathroom on the first floor, one in the bathroom on the second floor, one in the kitchen, one in the utility room and one in the second utility room) none of which had soap and hand towels to be able to hygienically hand wash. This meant people and staff were unable to wash their hands after using the toilet, before administering medicines and preparing food. The staff told us it had been this way for as long as they can

remember due to the particular need of one person using the service. The staff told us no alternatives had been made to ensure staff and people were able to wash their hands and promote their hygiene. The manager made the finances available to ensure soap was purchased for all the sink areas, which we saw in place on our second day. We shared our concerns about the cleanliness and safety of the premises with Environmental Health.

We observed that the provider had an infection control annual statement on display, which included the following: 'Staff undertake monthly Health and Safety Audits, where the cleanliness and hygiene / safety of the service and equipment are inspected. United Response managers undertake monthly and quarterly audits, which inspect premises / environment and practices'; this was written in September 2015 and is due for review in September 2016. There was no evidence that these checks had taken place in 2016. We discussed these issues with the area manager who told us they were equally concerned. An external cleaning company was contacted and a deep clean of the premises was arranged prior to the second day of our inspection. However, upon return these issues had not all improved. We looked at the cleaning records for the service and found that none had been completed. We asked the senior support worker and staff about these records; they told us some cleaning was taking place during the daytime but were not able to ascertain when and how often the cleaning had taken place. The systems in place to ensure the cleanliness of the environment had not been effective in ensuring people received care in a hygienic and safe setting.

We found that effective systems were not in place to ensure people's medicines were managed safely. We observed that medicines were not always stored in accordance with the manufacturer's safety guidelines. For example, a person who was prescribed topical cream requiring refrigeration had it stored in the fridge, which had the high temperature reading. This meant the provider could not assure people that their medicines were safe or effective to be administered. Accurate records, for example, monitoring medication stocks, records relating to medication, which, had been returned to the pharmacy, were not maintained to ensure the provider could account for all the medicines at the home. This meant people may not have received their medicine as prescribed.

The above evidence demonstrates that the provider had failed to provide care and treatment in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff did not understand their responsibility in identifying, recording and reporting suspected abuse or neglect. The provider's safeguarding policy was out of date and had not been reviewed since 2013; it therefore did not incorporate significant changes in the safeguarding legislation that came into practice in April 2015. It also did not contain the contact details for relevant agencies such as the local safeguarding team and The Care Quality Commission for staff to know who to report to.

We found at least two incidents of alleged physical abuse that had not been discussed with or reported to the local authority safeguarding team in accordance with local and national guidance. Staff told us they did not know these incidences were reportable. There was no evidence to show that the provider was learning from incidents of alleged abuse to prevent further incidents from occurring. For example, care records showed one person was assaulted by another person because they felt they were too close in proximity.

Staff had been giving one person an over-the-counter herbal medicine that can be used for short periods to relieve stress and sleep disturbance. Two tablets were administered to the person, each morning and evening. Staff told us they had been doing this for the past eight years in order to aid the person's sleep. The medicine was not prescribed and not reviewed by a healthcare professional such as their GP. The person was on other medicines that had a sedative affect, and there was no evidence that advice had been sought

to ensure they did not counter act with one another. In addition the use of this homely remedy did not follow manufacturer's guidance which states medical advice should be sought if symptoms do not improve after four weeks. The person was not consulted about this medicine or their consent given. Staff told us they were giving the person this medicine to improve the person's behaviours. We requested this be brought to the attention of the provider and for them to raise a safeguarding alert with the Local Authority. At the time of our visit, the senior support worker sought medical advice from a general practitioner (G.P) regarding the use of this medication and ensured the medication was discontinued following medical advice.

Staff demonstrated a lack of awareness and knowledge about responding to the hygiene needs of people. We observed some people's bodily odour to be malodorous and saw that some people were wearing the same clothing for three days, which had been soiled. This demonstrated a standard of care and treatment which significantly disregarded the needs of people and did not protect them from the risk of neglect or self-neglect.

The above evidence shows that people were not consistently protected from the risk of abuse, neglect or improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Prospective staff underwent a practical assessment and role related interview before being appointed.

Daily staffing needs were analysed by the acting senior support worker. This ensured there were always sufficient numbers of staff to support people. There were four members of staff on duty between 8am and 3.30pm. One member of staff on duty from 2pm to 10pm, this person slept at the service and was available to support people if needed. The service had a 24 hour on call system in case additional staff were needed. Rotas we reviewed confirmed there was always sufficient staff to meet people's needs. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Checks were made by suitably qualified persons of equipment such as the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff, in how to support people to evacuate the premises in an emergency.

Requires Improvement

Is the service effective?

Our findings

Staff said they rarely received performance supervision. When we checked supervision records, we found that this had been irregular. The provider's policy stated that supervision was expected six times a year; we found that staff had not received supervisions this frequently. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff or manager. Staff told us they felt unsupported. Staff said that they were sent on training, but this was not embedded through 1:1 meetings or through team meetings. The provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views. Staff told us that this had impacted their morale and they did not feel valued. Throughout the inspection we observed examples whereby staff demonstrated a lack of understanding of people's needs and how to keep them safe. This had not been highlighted through regular staff supervision and training to ensure staff skills and knowledge were up to date.

The new acting senior support worker had been transferred to Burnham Avenue from another service without any form of induction. The senior support worker told us they were transferred in July 2016, but had not yet been informed when their support and supervision would be, or received any form of induction into the new role. The senior support worker attended a training session in the previous week to the inspection and was informed at that point they were able to have a full day admin shift each week. Prior to being told this, they had tried to juggle their new responsibilities of overseeing the service, while on shift.

Staff told us they received some training to help them to meet people's needs. However, they told us and staff records showed there were significant training gaps. For example, staff told us and we observed that they did not have the knowledge and skills required to meet the needs of people who displayed behaviours that challenged. One staff member said, "I just googled the diagnosis and printed off guidance that way". Another staff member told us, "I've not had training in Autism; I just use my own experience ". Another staff member said, "We are just expected to get on with it".

Specialist training was not provided on the specific needs of people living at the service. The training identified as being needed in the care plans were autism awareness, managing behaviours that challenge, fragile x syndrome awareness and other diagnosed conditions that required a skilled approach from the team. The impact of this meant staff did not know how to meet people's needs. For example, we observed staff unable to support a person with their escalating behaviours in line with best practice. This resulted in the person becoming increasingly distressed and anxious, which placed them, other people and staff at risk of harm to their safety and wellbeing. This showed that staff training and support did not equip staff with the competencies and confidence to ensure people's safety and meet their needs.

The failure to ensure staff received appropriate supervision and training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found other staff had completed an induction course based on nationally recognised standards and spent time working with experienced staff before they were allowed to support people unsupervised. This

ensured they had the appropriate knowledge and skills to support people effectively. Staff told us their induction programme gave them the initial skills and confidence to carry out their role effectively. Staff had also completed the new Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that care workers are expected to achieve nationally.

Staff received generic training provided by the service when they joined as part of their induction programme. There was a training programme in place, which was monitored by the provider. All staff had to complete annual refresher training. Examples included safeguarding, health and safety, first aid, safe medicines administration, moving and handling, deprivation of liberty safeguards and mental capacity. However, as previously stated, this training did not ensure staff understanding and competency in all areas.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had a good understanding of the Mental Capacity Act 2005 (MCA); however, this was not always demonstrated when making best interest decisions for people who were deemed to lack capacity. For example, staff confirmed that people could consent to most decisions concerning their day-to-day support by using communication techniques individual to the person. Mental capacity assessments had been completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing or finances. However, best interest decisions did not always include the appropriate professionals, advocates and relatives.

There had been no mental capacity assessment and best interest decision completed for two people regarding their clothes being kept in the staff sleep in room. Staff told us they were kept away because the person would put their clothes on the floor, and could not always cope with too many choices on what to wear. We could not see that consideration had been given to whether the restriction was proportionate and the consequences of not having the restriction in place were not highlighted in their care plans or risk assessments. We could not see that consideration had been given to ensuring the restriction in place was not any more restrictive than was necessary. In addition, a decision had been made over time by staff to administer an over the counter medicine which was not prescribed or and the person had not consented to it. There was no best interest process to determine that this medication was in the person's interest. We have expanded upon this example in the Safe domain of the report.

We recommend the provider refer to the Mental Capacity Act 2005 and its codes of practice to ensure this is consistently applied by all staff. The area manager and new manager demonstrated a sound understanding and knowledge of the MCA and agreed to review the concerns we highlighted without delay.

A DoLS authorisation form had been completed appropriately for three people due to the restrictions posed on them reference to their finances and medication.

We found that prompt referrals to health and social care professionals were not always made in response to

peoples' changing needs. In the Safe domain of this report we specifically reference examples where appropriate advice had not be sought in relation to changes in people's mobility, behaviours, medicines and continence. Staff told us no referrals had been made in relation to these changes. This meant that the provider and staff could not be assured that staff were supporting people appropriately in relation to their changing health and care needs.

In contrast, there were other examples where people's needs were effectively monitored and managed in other areas. For example, staff understood the impact of health appointments, and worked with health professionals to address people's health needs without causing them distress. People were supported to maintain good physical health through regular check-ups with their GP, optician and dentist.

Each person had a health plan which documented their health appointments and reviews, and advice and guidance from health professionals. For example, one person was complaining of a sore ear. The staff supported the person to the GP who identified the ear had compacted wax. Staff then implemented the advice and guidance provided by the G.P. This demonstrated that health issues or concerns identified by staff were raised with and addressed by health professionals promptly.

People were supported to have enough to eat and drink and were provided with a balanced, healthy diet. People were encouraged and supported to prepare their own meals, snacks and drinks in accordance with their eating and drinking plans. We observed communal mealtimes where people and staff ate together.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were kind and caring. One person said, "the staff are very caring". Another person described the staff as, "Lovely, they always help me when I need it".

People we spoke with told us that staff respected their privacy and dignity. One person told us, "I get help with personal care; the staff do everything for me".

A healthcare professional told us "[person] has always been well cared for and other residents there appear the same. I have found the service to be very caring"

The people we spoke with told us they were able to express their views and make day-to-day decisions about their care. However, we could not find any further evidence that people were involved with planning their care. None of the three care plans sampled recorded people's involvement. As a result, there was no evidence that people or those who knew them best had been involved in planning or reviewing people's care.

People were not involved in their care planning and told us they did not know what was written in their care plans. One person told us, "I have no idea what is written about me". The three care plans we looked at lacked personalisation and there was no evidence that people or their representatives were asked what they wanted. People did not have an opportunity to comment on their care planning or whether their needs were accurately reflected. One person told us, they would like more involvement with their medication and finances. There was no evidence of how people were asked to be involved or what steps the provider had taken to try different ways of involving people.

The décor in people's rooms were not personalised and lacked a homely feel. People told us that they were not involved in how their rooms were decorated and did not have an opportunity to choose their curtains or furniture. The standard of hygiene throughout the home, including bathing facilities, did not uphold people's dignity. One member of staff said, "The bathrooms are awful". Another staff member said, "I wouldn't wash here". Looking at the bathroom, the manager and area manager said that they would not wish to bathe using the facilities. This has been explored in more detail in the Safe domain of this report..

We found scant evidence of people being encouraged or supported to learn new skills and become more independent. Staff gave people care and support but person centred planning was not used to help people develop skills or to have different experiences. Independence building was not to the fore in care planning and we found very little evidence to show that this was discussed with relatives, support workers, social workers or any other professionals who were involved with the care and support.
The above evidence shows that the provider had not ensured that care and treatment was provided that met people's needs or reflected their preferences. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us, "Everyone is so approachable. Very caring".

We did see a number of positive interactions between staff and people but there were occasions when people's privacy and dignity were not maintained. For example, we observed staff talking to other staff about a person's personal care routine in front of other people. On the first day of our visit, there was a person wearing clothes that had a fetid odour; no staff on duty identified this or supported the person to change. Two days later on the second day of our visit, the same person was wearing the same clothes. The odour had become worse, the inspector brought this to the attention of the manager, who agreed the clothes could not have been cleaned and they encouraged a staff member to support the individual to change. The manager had started an action plan during our visit, of how they were going to change this practice and ensure practice like this did not continue This action plan was shared with us at the time of inspection and with the area manager.

We observed a member of staff sensitively remind one person to fix their clothing to ensure their dignity was respected. Staff knocked on people's doors before entering and made sure they were happy for them to enter the room. We spoke with staff about how they ensured people received care in a way that promoted their dignity. Staff told us they ensured that door and curtains were closed before they offered support with personal care.

We did see some caring interactions. We observed staff crouching down to people's level to talk to them and spending time with people, engaging with them. We saw one member of staff interacting with a person who had limited verbal communicate skills. The interaction was natural and included banter that was well received by the person. During another interaction, we saw a member of staff sitting with a person talking about their plans for the day. The staff member had a good rapport with the person and was engaging them in the conversation.

We recommend that the provider ensures consistency in the caring approach of staff to ensure people's dignity and well-being are promoted.

Family and friends were able to visit without restriction. Relatives were made to feel welcome and felt comfortable discussing any changes or updates to the care their relative received. People were encouraged to stay in contact with people who mattered to them and family members had arranged times for people to call them.

Inadequate

Is the service responsive?

Our findings

We found that people's care records were standardised across the service with little evidence of individualised person centred care. There was no evidence that people were involved in the development of their care plans.

Care plans did not always reflect the assessed needs of people who used the service. Care plans lacked detail, were not always person centred, had not been reviewed when needs changed and lacked goals for individuals. Assessments and care plans were not being completed or reviewed by staff with the skills, competence and experience to do so. Care plans and assessments were of a poor quality and routinely reviewed stating "no change" even when changes had occurred during the review period. We found that there was a lack of management oversight for staff within the service to ensure that they were following care plans and understood people's changing needs.

Where people displayed behaviour which may be challenging they did not have any positive behaviour support plans in place, which detailed what behaviour may be displayed. The plans did not provide guidance for staff on how they should respond to behaviours displayed to reduce the likelihood of the person becoming upset. The plans did not detail triggers and early warning signs and lacked details for staff in early intervention strategies. There was no guidance around recovery phases and what should be observed after an incident. There was no guidance on how to use post incident strategies to support the person to remain calm. The provider has an internal positive behavioural support team who had not been referred to for their support and guidance. The impact of this meant people were not being appropriately supported in a personalised, skilled and proactive way around their behaviours and complex needs. After the inspection, we met with a director from United Response who gave assurances their positive behaviour support team have now been referred to and are in the process of assessing each person's needs.

The senior support worker told us they had identified that meaningful activities was an area which required significant improvement. However, plans to address this had not been put in place. Each person had an activity plan. The activities plan was displayed on a board in the dining room area. On both days of the inspection, we saw that people were going out to the gym, visiting the shops to do a grocery shop and one person visited a pub for a meal. However, we found that, although activities appeared to be taking place, there was no evidence to demonstrate how the activities timetable offered were based on the individual goals, aspirations, and interests of the people participating. We found no evidence in how those activities had been chosen and how people had been consulted.

We found that the provider had not ensured that people received care and treatment that was appropriate in meeting their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider managed complaints. There was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. However, this was in a file not accessible to people living in the service. People that we spoke to about this did not always know how to access it. There was no

evidence that people were spoken to about how they could make a complaint and multiple people told us that this was not discussed. There were no residents meetings and people were not met with on a one to one basis as an alternative mechanism for obtaining their feedback.

The service did not have a system of recording complaints. We identified concerns raised in people's daily notes completed by staff, but these concerns were not logged and there was no evidence that they were resolved within a reasonable timeframe to the satisfaction of the person. For example, one person had complained on a number of occasions about another person's behaviour in the home. This person told us their concerns were not discussed with them and they felt staff ignored this concern. We brought this to the attention of a member of staff on duty, who told us the person who the complaint refers to behaves that way daily. The senior support worker told us staff have got used to particular behaviours people can exhibit. Staff told us that people's views, concerns and complaints were not always documented and they tried to resolve them informally.

We found that the provider had failed to ensure they had an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

There was a systemic failure to manage areas of the service leading to people sometimes receiving poor quality and unsafe care. The provider had not ensured the service was using the appropriate systems for assessing, monitoring, mitigating risks and improving the service. The area manager left employment in July 2016 and the registered manager left employment in August 2016. At the time of our inspection, a new manager and new area manager had only just started their new posts. The provider had a lack of insight into the previous management team's failures to follow the provider's processes. There was a reactive rather than proactive approach by the management team, which meant that people did not receive a consistently safe and appropriate service. This meant that aspects of the service were failing and people were not always receiving their planned care.

The new area manager who took over from the previous area manager in July 2016, told us that all daily records, MAR charts and financial records should be audited monthly by the manager and quarterly by the area manager. The new area manager told us they had been with United Response for a number of years and that these processes had always been this way. However, we identified that only one audit had taken place in 2016 by the previous area manager and one audit taken place in 2016 by a manager, which was not in line with this policy. The audits that had been carried out were not robust; they had not identified the key issues found on this inspection, such as inappropriate over-the-counter medicines being given, the inadequate cleanliness of the service and the accuracy and personalisation of people's care plans. The former manager had completed an audit action plan in May 2016, but had not taken action to address their findings. This made the audit process ineffective. The provider had failed to take action to understand why the issues had arisen.

Audits undertaken by external health care professionals had not always been actioned to improve practices. For example, a local pharmacy conducted an external medicines audit in December 2015. It had an action plan for the service, which included updating their medicines policies, ensuring topical creams were labelled with the date open and considering the location where medicines were stored. None of these recommendations had been actions and we found these points were still of concern. For example, despite the pharmacist's suggestion to move the storage location of medicines, the medicine cupboard remained in the main part of the service near the dining room; we observed the area to be quite chaotic on occasions and this increased the risk of potential error.

People were at risk of harm as there was no system to understand people's medicine and the importance of individual's timings of medicines. There was no managerial oversight to establish that MAR charts correlated with people's prescribed medicines and no regular checks to ensure people had their medicines administered safely. The audits did not identify that people were at risk of not receiving their medicines as prescribed, and they failed to refer people to their GP for medical advice where people had not had their medicines.

The information contained in people's care records was not being effectively monitored or analysed by the provider to ensure people's needs were being managed effectively. For example, the provider had not

identified that plans were not in place to help staff manage people's behaviours that challenged. They had also not identified that incidents relating to behaviours that challenged, such as, alleged assaults on people were not being appropriately reported.

The provider had not identified that people were not always receiving their planned care. For example, people were not adequately supported with their mobility and continence needs to promote their safety and wellbeing. This showed that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and improved.

Effective systems were not in place to ensure the refrigerator was safe to use, that there was soap and handtowels for people to use and to ensure rooms were adequately cleaned. The staff told us hazard checks were completed each week. They also told us equipment would be immediately taken out of action if it was unsafe. However, we found these checks were either not being completed or they were completed ineffectively. The areas of this service we identified as a risk, had not been identified by staff, the previous registered manager, previous area manager or the provider as being unsafe. This meant people were placed at risk of harm to their safety and wellbeing.

Safety incidents were not always appropriately reported, investigated or managed to prevent further incidents from occurring. For example, staff were not recording incidents where people had been allegedly assaulted on incident forms. This meant these incidents were not investigated or monitored by the provider to reduce the risk of further incidents from occurring. Lessons were not learnt in response to incidents.

There was no robust system and processes to assess, monitor and mitigate risks or, monitor and improve the quality and safety. This is a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they did not feel supported by the provider and management. One staff member told us, their view of the management and leadership of the service as being, "Nothing is there (support), it's non-existent. I wouldn't know who to talk to if there were concerns". Another staff member told us "The management used to be good, four odd years ago. Now it is shambolic. There's no excuse". Another person told us "I wouldn't know who to report things to, people I knew have left. Regarding the management and leadership of this service, it is tricky. Most of us remember the good. However, our resources have been removed. It has not been good for four to five years. I stay because I worry what might happen to the guys [people] next". A new staff member told us they were unsure of who was in charge and what the systems were for reporting concerns. This meant there was a risk staff would stop reporting concerns to the provider as they did not feel listened to.

The provider had failed to notify us of at least two incidents of alleged abuse as required under our Registration Regulations. The area manager confirmed that this must have been a provider oversight at that time. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The area manager gave assurances that their systems for reporting would be reviewed to ensure this did not occur again. Since our visit, the provider has informed us of reportable incidences.

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 Commission (CQC) without delay of two incidences of an allegation of abuse. (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate, met their needs or reflected their preferences. Peoples care and treatment was not designed with a view to achieve service users preferences. The provider had failed to enable and support service users, to participate in making, decision relating to their care and treatment. (1) (a) (b) (c) (3) (a) (b) (c) (d) (e) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been processed and established to effectively prevent abuse in the service. Systems and process were not established and operated to effectively investigate, immediately in becoming aware of, any allegation of abuse. Care and treatment was on occasions provided

in a way that was degrading for a service user and with a significant disregard to the service users care or treatment.

(1) (2) (3) (4) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users. (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to make sure there were sufficient numbers of suitably qualified, competent and skilled staff. The provider failed to ensure staff received appropriate support, training, professional development, supervision to enable them to carry out the duties they are required to perform. (1) (2) (a)

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The provider had not done all that was reasonably possible to assess risks to health and safety, or do all that is reasonably practicable to mitigate such risks. Medicines were not safely or properly managed. The provider had failed to assess the risk and prevent, detect and control the spread of infection. (1) (2) (a) (b) (f) (g) (h)

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established effective governance systems to assess monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. (1) (2) (a) (b) (e) (f)

The enforcement action we took:

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