The Disabilities Trust

Ernest Kleinwort Court

Inspection report

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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?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

The inspection took place on 7 and 9 March 2018, the first day was unannounced and the second day was announced.

Ernest Kleinwort Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and personal care for up to 33 people who require support with their personal care. The service specialises in supporting younger adults with physical disabilities. There were 31 people living at the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. On the day of the inspection, the registered manager was not present and the service was being overseen by an acting manager.

The inspection was prompted in part by notification of an incident following which a person using the service was subject to serious harm. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However the information shared with CQC about the incident indicated potential concerns about the management of weight loss. This inspection examined those risks.

Risks to people's safety had not always been adequately assessed, monitored and minimised. This included risks associated with nutrition, choking, catheter care and skin breakdown. Care staff did not consistently have oversight of people's air mattresses settings and some air mattresses were set at the incorrect setting which placed people at risk of their skin breaking down.

People were not supported in a consistent manner to live healthier lives. Poor joint working meant people were also not supported in an effective manner to receive care and support that promoted their wellbeing. Poor documentation meant the provider could also not provide assurances that people had been supported to access healthcare services.

Documentation was not always fit for purpose or accurate. Discrepancies and gaps in recording had not consistently been identified by the provider as a shortfall and consequently the provider was unable to demonstrate if people received the care required or whether it was a failure to document the care provided.

People's care needs were not assessed in a holistic manner and staff members raised concerns that people were not always supported to meet their social and psychological needs. One staff member told us, "Activities are not strong." Whilst end of life care plans were in place these lacked guidance and detail. This is

an area of practice that needs improvement.

The principles of the Mental Capacity Act (MCA) 2005 were not consistently applied in practice. A range of restrictive practice was in place, but the care planning process failed to identify if care could be delivered in a least restrictive manner.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a delivery of consistent high care across the service or pro-actively identified all the issues we found during the inspection.

People spoke highly of the food provided. One person told us, "It's like going to the Savoy every day." However, risks to people with complex care needs had not been identified or managed in relation to their eating and drinking. Risks associated with weight loss were not managed effectively.

The management of medicines was not consistently safe. Staff members felt there was blame and shame culture. Staff members felt devalued. One staff member told us, "We need strong management." People were not consistently protected by the prevention and control of infection. A range of training was available for staff, however, staff felt training did not always provide them with the required skills and abilities. We have identified this as an area of practice that needs improvement.

People's right to privacy was respected. Staff knew the people they were caring for very well. It was clear that permanent members of staff had built positive rapports with people. Recruitment checks were carried out to ensure suitable staff were employed to work at the service.

People's individual ability to evacuate the service has been assessed and evacuation plans were in place. Safeguarding policies and procedures were available for staff to access and people told us they felt safe at the service. A range of group activities took place and the provider employed a dedicated activity coordinator.

We found a number of breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the registered providers to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

Ernest Kleinwort Court was not consistently safe.

Arrangements to manage risks appropriately were not in place and placed people at risk of receiving unsafe care. Risks associated with skin breakdown, catheter care and behaviours that challenged lacked sufficient guidance and detail.

People were not consistently protected by the prevention and control of infection. The management of medicines was not consistently safe.

Staffing levels were sustained with regular input from agency staff. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

Is the service effective?

Inadequate

Ernest Kleinwort Court was not effective.

People were asked their consent for day-to-day decisions; however, the principles of the Mental Capacity Act (MCA) were not consistently applied in practice.

Risks to people with complex needs were not identified and managed consistently. People were not consistently supported to live healthier lives. Staff failed to work effectively with other healthcare professionals to deliver effective care, support & treatment.

The training provided did not always enable staff members to feel equipped and confident to provide effective care.

Is the service caring?

Requires Improvement

Ernest Kleinwort Court was not consistently caring.

Most people received care that was kind and caring. People raised concerns over the mannerism and calibre of some staff members. Staff faced various challenges to provide compassionate care.

Visiting was not restricted. People were able to make their feelings and needs known.

People's right to privacy was respected.

Is the service responsive?

Requires Improvement

Ernest Kleinwort Court was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Pre-admission assessments could not be located and holistic care planning and assessment of people's needs had not taken place. End of life care plans were in place but these lacked detail.

There was a complaints policy in place and people and visitors told us they would raise any concerns with staff. Technology was utilised and accessible for people to maintain contact with their friends and family.

A range of group activities were available for people to access.

Is the service well-led?

Inadequate

Ernest Kleinwort Court was not well-led.

There had been insufficient oversight to recognise a decline in standards of quality and safety.

Assessment and monitoring of risks to people had not been successful in a number of areas. Staff felt devalued and poor communication meant good outcomes for people were not being achieved.

Accurate, complete and contemporaneous records had not been maintained.

Ernest Kleinwort Court

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 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 7 and 9 March 2017 and was unannounced. The inspection was carried out by four inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This 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 reviewed the information we held about the service, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the service. These included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at nine care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' people living at the service. This is when we looked at their care documentation in depth and obtained views on their life at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with seven people who lived at the service, one visiting relative, the acting manager, divisional manager, two assistant managers, cook, activity coordinator and seven care staff. We also spoke with seven relatives by telephone to gain their views of the care provided to their family members. We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed medicines

being administered to people.

The last inspection of the home was 5 and 6 October 2016 where we found areas of practice that needed to improve. The home was rated 'Requires Improvement'.

Requires Improvement

Is the service safe?

Our findings

Most people told us they felt safe living at Ernest Kleinwort Court. One person told us, "I feel safe and have no concerns." Some people raised concerns. One person told us, "I don't like it here anymore." Another person also told us that they no longer felt safe at the service.

Robust arrangements to manage risks appropriately were not always in place. Risk assessments failed to follow good practice guidance and control measures were not adopted or amended in line with changing practice. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. For example, a number of people had a catheter in situ. Care plans and risk assessments failed to provide sufficient guidance on how to safely care for the catheter and reduce the risk of catheter inquired infection. Best practice guidelines by the National Institute for Health and Care Excellence (NICE) advise that 'effective catheter care requires good management of infection control, hydration and monitoring for signs of catheter acquired infections. Healthcare workers should make sure that a record is kept of the catheter care, including catheter leg bag changes.' Information was not readily available on how often people's catheter leg bags should be changed to mitigate the risk of cross infection. Staff provided contradictory information with one staff member advising they were changed weekly whereas another staff member commented that it should be twice a week. The provider was unable to provide assurances that people received the support required to safely manage their catheter and reduce the risk of infection. Inconsistent understanding of people's care needs and lack of recording placed people at increased risk of not having their health needs met consistently.

Risks associated with pressure damage was unsafe and placed people at risk of further skin breakdown. Care and support was provided to a number of people with complex healthcare needs and reduced mobility. Input was provided by the district nursing team to support people's skin integrity; however, robust risk assessments were not in place to enable staff to provide safe care. For example, one person's care and risk assessment noted that they were susceptible to pressure sores and that staff should follow the district nurses care management programme. The district nurse care programme was not reflected or embedded within the body of the risk assessment and the risk assessment had not been updated when the person's skin integrity had significantly deteriorated. Steps to proactively mitigate the risk of skin breakdown had not been actioned and the provider had not given consideration to assessing people's risk of skin breakdown using nationally recognised best practice guidelines such as Waterlow (Waterlow – tool for assessing skin breakdown). Risk assessments failed to identify if people could reposition themselves or if support was required. Where people were unable to reposition, repositioning charts had not been instigated to demonstrate that people were supported to reposition and alleviate the pressure on the susceptible area of skin. For example, one person was unable to reposition and this was confirmed by staff and the person. They were experiencing skin breakdown yet staff advised that they did not support the person to reposition.

Some people received care and support on an air mattress (inflatable mattress which could protect people from the risk of pressure damage) and it is important that the setting of the air mattress matches the person's weight. Risk assessments failed to reflect what the setting should be and where people had

brought their own air mattress into the service, manufacture guidelines had not been sought to identify how the mattress worked and whether the mattress was on the correct setting for the person's weight. For example, one person received care on an air mattress which was on the setting of 60kg but should have been 100kg according to their weight. We brought these concerns to the attention of the management team to take immediate action.

The management of people's percutaneous endoscopic gastrostomy (PEG) tube was not consistently safe. This is an endoscopic medical procedure in which a PEG tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding. Risk assessments and care plans were in place around the management of PEGs. These identified that the PEG should be rotated weekly. However, staff provided contradictory information on where they recorded the rotation of the PEG. One staff member advised it was recorded within their daily notes, whereas another staff member commented it would be within their observation sheet. We reviewed documentation over a four week period and found no reference to the rotation of the PEG. This posed a risk as staff did not have the information available to confirm when the PEG was last rotated.

Risk assessments to understand, prevent and manage behaviours that challenged lacked detailed guidelines. For example, a person's risk assessment identified that they could decline staff support. The risk assessment noted that if the person displayed these behaviours to report them. However, the risk assessment failed to identify what action should be taken if the person continually declined staff support and placed themselves at risk of self-neglect. Another person's risk assessment reflected that they experienced anxiety and could become agitated. Whilst the risk assessment noted potential triggers, de-escalation techniques were not available to ensure that all staff responded in a safe and consistent manner to the behaviours that challenged. One staff member told us, "There is no guidance on how to deal with difficult behaviours, and no debriefing afterwards." Where people had displayed behaviours which challenged, lack of managerial oversight meant that one incident had not been identified until a clinical audit took place five months later which noted that a person presenting behaviours which challenged was inappropriately transferred (staff members used inappropriate moving and handling techniques). The transfer had not been risk assessed and was found to be inappropriate and unsafe. Subsequently a safeguarding concern was raised by the provider.

Arrangements for making sure that the premises were kept clean and hygienic was inconsistent. Dedicated housekeeping staff were employed and monthly infection control audits were completed. However, shortfalls with the management of cleanliness and the prevention of infection were found during the inspection. A number of people received care in self-contained flats and bungalows. Whilst these promoted independence, support was not always provided to ensure people lived in a clean and hygienic environment. For example, one person was found to have out of date food in their fridge. Some flats and bedrooms were cluttered with stains on the floor, their kitchen areas and bathrooms were also cluttered with dust and dirt present. Layers of dust were identified in some flats which also presented as fire hazard on the back of people's fridges (build-up of dust on electrical components increases the risk of fire). People's wheelchairs were also observed to be encrusted with food debris and dirt. A dedicated laundry area was available to minimise the risk of recontamination of linen. However, systems to minimise that risks were not always followed. For example, during the inspection, we observed on two occasions, dirty laundry left on the floor in the laundry room. Guidance produced by the Department of Health advises that, 'any dirty linen should be carefully removed from the person's bedroom and placed in the designated bag or container, not placed on the floor. This heightens the risk of cross contamination.'

Systems were in place for the administration and management of medicines; however, these were not always consistent and safe. Staff ordered prescriptions according to what was needed. Most peoples'

medicines were supplied in 28 day monitored dosage system blister packs (MDS) and printed medicines administration record charts (MARs) were provided. Medicines were stored in locked cabinets in peoples' rooms, the keys for which were held by the team leader. People had individual medicine profiles in place which included pertinent information, such as information on any allergies and how the person wished to receive their medicines. Staff administering medicines had access to the medicines policy, NICE guidelines, patient information leaflets and a copy of the British National Formulary (BNF). This helped staff to keep up to date about diverse medicines and be able to respond to questions from people. Medicines no longer required were stored and recorded safely and disposed of appropriately.

The provider's PIR reflected that a high number of medicine errors had occurred in the past year. The provider identified during the inspection that they were experiencing issues with the storage of medicines. One staff member told us, "People's medicines are stored in their individual bedrooms. However, the cabinets are too small and we are experiencing issues with high temperatures where medicines are stored in the cabinets alongside issues with the storage of topical creams and staff not always recording the temperatures of the cabinets." Medication audits were completed monthly and findings from the February 2018 audit found continued issues with temperatures not consistently being recorded alongside gaps in MAR charts where staff had failed to record that a topical cream had been administered. Incident and accident analysis between December 2017 and March 2018 found that 39 incidents were medicines related. One staff member told us, "There is a culture of name and shame. Medicines errors should be great learning opportunities but they are not being learnt from. One staff member is trying to do their best with medicines. Storage temperatures are often over 25 degrees. We have run out of medicines and I've found out of date meds. There isn't enough training. I was shown half a morning round and then passed as competent. There is no time to do it properly." The storage of topical creams was not consistently safe. For example, one person's topical cream was observed to be left on their bedside table. However, the storage instructions stated that it should have been stored below 15 degrees but was exposed to room temperature.

There were protocols in place for staff to follow when administering medicines that were prescribed to be taken on an 'as and when needed' (PRN) basis. However, these lacked detail. For example, one person was prescribed pain relief on a PRN basis, the guideline failed to identify where they experienced the pain or whether they could tell staff they were in pain. The provider's policy for the use of 'as required' medicines stated that, 'if a PRN medication is required on a regular basis that it should be reviewed by the G.P prescriber.' We saw a number of examples whereby people were having PRN medicines on a regular basis without a GP review. This posed the risk that people's medical condition may have changed and the treatment required might need altering.

The care and support people received was not safe and processes and checks were not in place to ensure safe care and treatment. This was a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought the above concerns to the attention of the provider who was responsive to our concerns and took immediate action to ensure the safety of people residing at the service. Immediate action was taken to assess and review all risk assessments. The provider also advised that additional environmental resources have been provided to resolve the infection control and cleanliness concerns.

People were protected from being supported by unsuitable staff. The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, work histories, proof of right to work in the UK and health checks. The provider also routinely carried out checks with the Disclosure Barring Service (DBS). DBS is the disclosure barring service. This is used to identify potential staff who would not be appropriate to work within social care. People who used the service were

also actively involved in the recruitment of potential staff members and devised questions for staff members to answer at interviews. For example, a recent recruitment meeting held with people in February 2018 found that people wished for potential staff to be asked what motivated them and their understanding of a support worker.

Staffing levels were based on people's individual care needs. Staffing levels in the morning consisted of 15 care staff in the morning and 14 care staff in the afternoon. People and their relatives felt staffing levels were sufficient. One person told us, "Staff are there if I need them." Another person told us, "Staff are always around when I need help." Staff rotas confirmed that on nearly every shift there were agency staff members. The provider was taking steps to actively recruit staff; however, in the interim, agency staff were used to maintain staffing levels. Staff and people recognised the need for agency staff but felt the main impact of this was that people were not always familiar with agency staff. One staff member told us, "The other week, there was one shift whereby only two staff members were permanent, all other staff members were agency. This can be challenging especially supporting people with complex and challenging care needs. They need familiar staff faces." This was an area of practice that was being addressed by the provider.

Observations identified that people's basic care needs were met by the deployment of staff. However, we identified concerns with meeting people's social, emotional and psychological needs which we have discussed under the 'Responsive' section of the report.

Regular maintenance and environmental checks had been completed. Fire evacuation and emergency procedures were displayed around the service. Staff and people had access to clear information to follow in the event of an emergency, including Personal Emergency Evacuation Procedures (PEEPS). PEEPS included individual information about people and things which need to be considered in the event of an emergency evacuation. An emergency contingency plan was in place that gave staff information of the action to take in emergency situations that included fire and floods. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events.

Safeguarding policies and procedures were readily available and accessible to staff. Training documentation confirmed staff had received training in adult safeguarding and staff told us they would have no hesitation in raising concerns over a person's safety. Arrangements were in place for reviewing and investigating safety and safeguarding concerns. For example, a member of the management team advised that following recent concerns raised, they conducted a review to identify if the concerns raised related to the quality of care provided or were safeguarding in nature.

Guidance produced by the epilepsy society advises that epilepsy is more common in people living with a learning disability. Where people had a diagnosis of epilepsy, protocols were in place which had been signed off by the GP. Epileptic seizure monitoring charts were in place which included documentation on the duration of the seizure, whether emergency medicines were administered and support provided post the seizure. Staff told us they felt confident with managing seizures.

Inadequate

Is the service effective?

Our findings

People and relatives told us the staff team were effective and received the necessary training to enable them to carry out their role. One person told us, "The staff are very good here and look after me well." A relative told us, "The staff try their best." People were also complimentary about the food provided. One person commented, "The food is fabulous here." However, despite people's positive comments, we identified areas of care which were not effective.

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 so that they can 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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Training records demonstrated that most staff had received MCA training and told us how the understood the importance of gaining consent and empowering people to make their own decisions. This was observed in practice during the inspection.

However, the provider was not following the principles of the MCA 2005 Code of Practice. A range of restrictive practice was in place at Ernest Kleinwort Court. For example, the use of bed rails, lap belts and head straps. Whilst the provider had recognised that people may be deprived of their liberty and submitted appropriate DoLS applications to restrict people's freedom who needed continuous supervision in their best interest. These applications failed to reference the use of restrictive practice (lap belts, bed rails and head helmets) and decision specific mental capacity assessments had not been completed to identity if people consented to the use of the restrictive practice or not. A member of the senior management team told us, "Mental capacity assessments should be in place." However, these could not be located during the inspection and this posed the risk that guidance was not available for staff on whether people lacked capacity to make specific decisions. When receiving care in bed, some people required bed rails and were subject to thirty minute or hourly observations. However, the care planning process failed to identify how peoples care and support could be delivered in a least restrictive manner. For example, whether care could be delivered on a low profile bed instead of the person requiring bed rails.

Applications to deprive people of their liberty had been submitted and one person's application had been authorised. However, the authorisation lapsed in June 2017 and a subsequent application had not been made. Therefore the person had been unlawfully deprived of their liberty.

Failure to work within the principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Lack of organisation and inconsistencies with recording meant we could not be assured that people's

healthcare needs were met effectively. Links with the local GP surgeries had been established and a local GP visited the service every week to discuss people's healthcare needs. On the 23 February 2018, documentation noted that it was identified that four people required a SALT (speech and language therapist) referral. It was not clear whether that referral had been made and staff members provided varied accounts of who was responsible for making that referral. One staff member told us that it would be a member of the management team but they would not be informed when the referrals had been made. One member of the management team told us the GP was responsible for making the referrals. We brought these concerns to the attention of the management team and requested confirmation that SALT referrals had been made.

Before the inspection, we received information of concern regarding how a person was transferred to hospital. We therefore looked at the management of hospital transfers. Whilst staff were able to explain whether people became anxious or agitated regarding attending hospital appointments. Guidelines produced by the National Institute for Health and Care Excellence advise that 'when people with care and support needs transfer into and out of hospital, good communication and integrated services are essential.' A member of the senior management team advised that hospital transfer information should be readily available; however, this information could not be located during the inspection. People's individual care plans also failed to provide clear guidelines on how to support people to ease their agitation around hospital appointments. This posed a risk that people were not effectively supported when they moved between services.

Care and support was provided to a number of people living with a learning disability. Best practice guidelines produced by NHS England advise that people with a learning disability should be supported to complete a 'health action plan.' This is a tool kit to support people to remain healthy. A member of the senior management told us that health action plans should be in place; however, poor organisation of paperwork meant these could not be located during the inspection. Lack of organisation and poor paperwork also meant we could not be assured that people were regularly supported to see their local dentist and other healthcare professionals. One person told us, "The GP visits regularly which is good." Some people were able to tell us that they received support to meet their healthcare needs. Whereas some people could not. The provider was therefore unable to demonstrate that people consistently received the required input from healthcare services to maintain their health and wellbeing.

Records relating to the care and treatment of each person using the service were not fit for purpose. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported in a consistent manner to live healthier lives. Poor joint working meant people were not supported in an effective manner to receive care and support that promoted their wellbeing. For example, one person experienced significant skin breakdown which was down to the tendon (bone). However, ineffective communication between staff and the district nursing team meant the status of the wound had not been flagged as deteriorating. One staff member told us, "One person was referred to the district nurses, however by that time you could see the tendon. I felt it should have been a team leader, not me, accompanying the district nurse to see the damage. They did arrange pressure area care training for us before the incident so we know what to observe and report, but prevention isn't a key thing here." The staff member commented that they felt this pressure damage could have been avoided. This was subsequently raised as a safeguarding concern during the inspection process.

Lack of understanding and poor communication also meant people were at risk of not receiving vital care to manage their skin care. For example, one person was living with a chronic wound. A care plan devised by the district nursing team dated 4 March 2018 noted that care staff were attending to the wound. However, we

received contradictory information from staff about the management of the wound. Some staff member advised that the wound was dealt with by the district nurses whereas other staff advised that they supported the person to manage their wound. Care and risk assessments failed to provide guidelines on the actions required by staff to manage the wound. This posed a risk that vital care would not be provided. Regular use of agency staff also added to the risk that this individual would not receive the support required to maintain their health and wellbeing.

Risks to people with complex needs were not consistently identified and managed in relation to their eating and drinking. A nutrition and hydration policy was in place which stated that a nutritional assessment should be carried out on admission to the service to identify any risk of poor nutritional or dehydration. The policy also stated that if a nutrition and hydration risk was identified later on, a care plan should be developed that incorporates information gathered from the outcome of nutritional screening. The provider was not following their internal policy. Nutritional risk assessments such as MUST (malnutrition universal screening tool) scores had not been calculated or assessed in a number of years. A member of the management team told us, "We were told a number of years ago that we were not required to complete them unless necessary. However, this wasn't recorded so it looks like we just stopped assessing MUST scores." Care and support was provided to a number of people who were regularly refusing to eat and drink. Where people had been losing weight, consideration had not been given to completing a nutritional screening assessment or MUST score as detailed within the provider's nutrition and hydration policy despite their weight loss. Where people had lost weight, their individual nutritional care plan had not been reviewed to identify the weight loss and there was no evidence of any consideration given to making a referral to the dietician.

Where people were refusing to eat and drinking, food and fluid charts lacked strategic oversight to monitor their daily intake. Food and fluid charts also failed to reflect any evidence of snacks offered between meals to promote nutritional intake. Although people were weighed on a regular basis as part of their monthly key-worker report, there was no analysis of their weight from one month to the next. Some people did not always allow for staff to weigh them but this was not documented in their care plan. For example, one person was weighed in December 2017 but not weighed again until March 2018 when they had lost 11.3kg. Where people declined to be weighed, care documentation failed to identify what actions were required to manage potential weight loss and how staff ensured the person was maintaining a healthy weight. One person signed a disclaimer in September 2016 advising that they did not wish to be weighed. However, this individual's health was deteriorating and they were now refusing to eat and drink at times and staff members felt they were losing weight. However, no plan of care was in place to address this and ensure there nutritional needs were being met. The provider had failed to give consideration to whether alternative methods of assessing weight should be considered.

Failure to meet people's nutritional and hydration needs and provide safe care and treatment is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Despite the concerns above, people spoke highly of the food provided. One person told us, "It's like going to the Savoy every-day. I've put on over a stone in weight since moving in here." Another person told us, "The chef is wasted here, he's very good. The food is amazing." A relative told us, "The food is amazing. (Person) loves the food and has put on weight since moving into the service." A member of the kitchen told us that the menu was based on people's likes and dislikes and they gained direct feedback from people regarding the meals. The menu was on display and people confirmed that menu alternatives were available such as omelettes and jacket potatoes.

Guidance produced by Skills for Care advises on the importance of a 'strong skilled workforce. As part of

staff's induction to Ernest Kleinwort Court, staff shadowed other staff members. If staff members were new to care, they completed the Care Certificate. The Care Certificate sets the standard for new health care support workers. The registered manager recognised the importance of staff development and training and the PIR advised that one staff member was being supported to obtain their level five leadership diploma in health and social care. A range of training had been provided to staff which included training on safeguarding, moving and handling, epilepsy and de-escalation and intervention. However, staff members had mixed opinions around the training provided. One staff member told us, "Training is good, it's constant and the trainer is brilliant." Whereas one staff member told us, "We are not an autism home but we have people on the spectrum and haven't had any training about autism." Another staff member told us, "I didn't get any training on being a team leader, I've learnt as I've gone along. I had a manager sit in on the first supervision I did and was told I did it right; I haven't had any training in supervising staff. I have said in my own supervision I'd like some assertiveness training to help with directing staff to allocated work, but it hasn't come. I was signed off as competent with medicines and that seemed an appropriate process, but I'd like more training and oversight regarding signing in medicines at the beginning of the month."

Staff members advised that they did not constantly feel supported within their role and felt training was not always available to equip them to provide effective care. We have therefore identified this as an area of practice that needs improvement.

Requires Improvement

Is the service caring?

Our findings

People were supported by primarily kind and caring staff. Staff demonstrated an understanding of the preferences and personalities of the people they supported and with whom caring relationships had been developed. One person told us, "Staff are brilliant and they have good banter." However, despite these positive comments, we found areas of care which were not consistently caring.

Despite people's praise for staff, some people raised concerns over the mannerism and calibre of some staff members. One person told us, "Some staff are nice and we get along brilliantly, whereas others. There mannerism isn't always nice. The other day, a staff member had a go at me. Previously I haven't always spoken up for myself but I spoke up then as I didn't feel it was justified, them having a go at me." We brought these concerns to the attention of the senior management team and have identified this as an area of practice that needs improvement.

People were at risk of receiving care that was not consistently caring and did not promote their wellbeing. For example, people were not always supported appropriately to meet their nutrition and healthcare needs. People were also at risk of receiving care in an environment that was not clean or hygienic. We have discussed the associated risks of this within the 'Safe and Effective' section of this report.

Systems and support was in place to enable people to be as independent as possible. Some people had facilities in their individual flats and bungalows for making hot drinks and snacks whilst other people had their own kitchens in which they could prepare their own meals. The service also had a training kitchen whereby people could learn independent cooking skills. A washing machine was also in the training kitchen where people could also learn to do their own laundry independently. The service was fully adapted for people who used wheelchairs. For example, door handles and work tops were at an appropriate level so that they were accessible for people and they did not need support from staff to use them. Within the main lounge area was access to hot and cold drinks and we observed people independently making their own drinks. People had also been supported to find employment and one person told us how they were off to work for the day.

On a monthly basis, people were supported to set goals to achieve, which could include promoting their independence. We found some monthly reviews had lapsed and therefore it could not be ascertained whether people had achieved their goals or not. Where monthly reviews had taken place, documentation failed to identify if the person had achieve their goal or if they were still working towards it. Where goals had been identified, the date the goal had been agreed was not documented. Therefore, the progress of the goal could not consistently be monitored. One person told us how they were planning to move into more independent living arrangements. One member of staff told us they were supporting the person to promote their independence with cooking. This was not reflected within their care documentation. Failure to record the steps taken to promote independence meant the individual's progress could not be monitored.

Failure to maintain accurate records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not always able to tell us about their experiences. We observed that people had good relationships with some staff members and they were happy and comfortable in their presence. Staff had developed positive relationships with people. With pride, staff spoke to us about people's likes, dislikes and how they supported people. One staff member told us how one person loved Michael Macintyre (comedian) and they enabled them to get tickets to go and see him with staff support.

Peoples' equality and diversity was respected. They were supported by staff to maintain their personal relationships. This was based on people's choices and staff understanding of who was important to the person, their life history and where appropriate their spiritual and cultural background and sexual orientation. Whilst documentation failed to identify people's religious needs or sexuality, people were supported to meet their spiritual needs. One person told us, "I attend Church every Sunday. Sometimes staff drive me or I get a taxi." Staff members also confirmed that other people were supported to access their place of worship.

Peoples' privacy and dignity were respected and promoted. We saw that 'please do not disturb signs' were displayed on people's bedroom doors when personal care was being delivered. Some people had other signs to hang on their doors as they wished, for example, one person's sign stated 'If my door is shut please will you open it' and another person's stated 'Please keep out!'. Staff demonstrated that they had a good understanding of the importance of maintaining people's dignity and treating people with respect. We observed they took care to ensure doors were closed when they were delivering personal care to people as well as when we were speaking with them about people's care needs. Staff knocked on peoples' doors and waited for a response before entering. One person told us, "The care isn't over bearing and staff respect my privacy."

People were supported to maintain relationships with people that mattered to them. We saw visitors arriving at different times of the day and they received a warm welcome from the staff. People and their relatives confirmed there were no restrictions around visiting. A visiting relative told us, "I can visit anytime and I'm always made to feel welcome. It such a lovely place here." People's partners often visited at weekends and stayed overnight. One couple lived together and other people told us they were visited by their family and that staff supported them to go to social clubs where they could meet up with friends. One person told us, "Staff recently supported me to attend my friends 21st birthday party."

Requires Improvement

Is the service responsive?

Our findings

Ernest Kleinwort Court was not consistently responsive to people's care needs. People's experience of responsive and person-centred care varied and not everyone received care that enhanced their quality of life.

The provider's policies and procedures stipulated that people's needs should be assessed before they moved into the service to check whether the service could accommodate their needs. A care plan should then be devised based on the pre-admission assessment. During the inspection, we requested to see people's pre-admission assessments. These could not be located. It could therefore not be assess whether a holistic assessment took place before people moved into the service which took into account their sexuality, religious, spirituality, emotional, social and communication needs.

Guidelines produced by NHS England advise that 'holistic and personalised care planning is forging a relationship between people and health and care services they access and what's important to them.' People had individual care plans in place which considered their environment, daily routine, personal care needs, nutrition and domestic activities. However, care plans failed to reflect and assess people's care needs in a holistic manner. For example, care plans failed to assess and record information on people's sexuality and the support required to maintain their sexuality. Information was provided on people's likes, dislikes and their hobbies, however, emotional and social care plans were not in place to assess if people were at risk of social isolation. People had individual weekly timetables in place; these were not dated. Therefore it remained unclear whether they remained effective and relevant. For example, one person's weekly timetable noted every day as 'free time.' The person told us that they enjoyed their own company but had enjoyed the recent quiz nights and takeaway nights. This was not reflected within their care plan and monthly reviews and there was a lack of consideration within the care planning process as to whether people's social and psychological needs were being met.

Staff members raised concerns that people were no longer actively supported to follow their interests and the risk of social isolation had heightened due to the loss of one activity worker. One staff member told us, "Service users don't get listened to like they used to. They do get activities and outings but it seems to be the same ones who go all the time. The loss of one of the activity workers has made a big difference and support workers aren't very involved. I feel one person needs a lot more time spent with them. People who spend a lot of time on their own don't get much engagement if they don't have family visits." Another staff member told us, "Activities are not enough." During the inspection, we observed an afternoon music session whereby people sang along and played musical instruments. Whilst some people enjoyed this interaction, other people remained in their rooms. One relative raised concerns over staff not always informing their loved one of what activities were taking place and consequently they were not always supported to engage with group activities. Relatives also raised concerns that their loved one was not supported to go on a trip out once a week. They advised that their loved one became rather upset and felt low if they did not receive regular support to go out. They advised that the weekly trip out did not always happen. Staff members told us that they did not have time to visit people apart from when providing care. One staff member told us, "Management criticise the lack of activity and say there are enough staff. There is definitely less community

access than before."

People did not always receive personalised care that was responsive to their needs. Following a hospital admission, one person was diagnosed with depression. However, this diagnosis was not reflected within their care plan. Information was not provided on how the person experienced depression and what personalised support was required from staff. Some people were always living with mental health needs. Whilst their risk assessments reflected they received input from their CPN (community psychiatric nurse), the care planning process failed to holistically assess their needs including their mental health needs. For example, how their mental health needs presented and how those needs impacted upon their other care needs.

Some people were supported to engage in a monthly keyworker report which considered various aspects of their care such as general health, social, mood and behaviour. However, these monthly reports failed to consider the person's care needs in a personalised and holistic manner. For example, the keyworker monthly report for one person noted in December 2017 that they were in hospital due to a break down in their mental health. Their monthly report dated January 2018 failed to identify how the person was following their hospital admission or the impact on their general wellbeing. Instead the monthly report noted that they had a pressure sore which was being seen to by the district nurses. No consideration had been given to how the pressure sore was impacting on their general and mental health. We brought these concerns to the attention of the senior management team who confirmed there was a lack of holistic care planning.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet peoples' information and communication needs. People had a communication profile in place which identified how they required support to communicate. One person's communication profile stated that they were unable to communicate verbally and will communicate via blinking. However, information such as care plans was not consistently available in accessible formats. For example, where people were unable to verbally communicate, pictorial care plans were not in place. Whilst care plans recorded sensory and communication loss, proactive steps had not consistently been taken to ensure people's communication needs were met in a personalised manner. This posed a risk that for people supported by agency staff there was a lack of guidelines on how to effectively communicate with them in a person centred manner.

Failure to provide care that is reflective of people's needs and personalised is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Whilst no one who used the service needed end of life care at the time of our inspection, end of life care plans were in place. However, these had not been completed or lacked detail. Guidance produced by NHS England advises, 'It is important to view all people holistically when providing end of life care. People with a learning disability, like other members of society, will have a range of characteristics that may inform their needs and expectations in relation to end of life care. For example, expectations about end of life care may be shaped by someone's ethnicity, faith, values and/or other beliefs. It is important not to make assumptions about the care the person needs because of their learning disability diagnosis." We have identified this as an area of practice that needs improvement.

A programme of group activities was displayed within the service and a dedicated activity coordinator was in post. A range of activities were on offer which included gardening club, quizzes and trips out to local garden centres, museums and Zoos. External entertainers also visited the service including PAT animals,

singers and musicians. The activity coordinator told us, "We also hold cookery sessions twice a week and have volunteers who visit and support with the gardening club. I also keep abreast of forthcoming films and theatre productions in the area and these are publicised on a wheelchair-height notice board where people can sign if they would like to go." During the inspection, people were signing up to go and see one film and the activity coordinator was also taking one person to the theatre on a one to one basis the following week.

The use of technology was utilised throughout the service to support people to maintain relationships with their friends and family. The service had a computer which people could access and people had their own mobile phones and IT equipment which enabled them to regularly talk with their family and friends.

There were arrangements to listen to and respond to any complaints. People told us they felt confident speaking up and raising any concerns. Information on complaints was available in the service user guide which people received when they moved into the service. The provider had received three complaints since January 2018. Each complaint had been acknowledged, however, for one complaint we were unable to locate a response letter. We brought this to the attention of the management team to action.

Inadequate

Is the service well-led?

Our findings

The provider's vision and strategy was not being followed to deliver high quality care. A positive culture was not promoted and good outcomes for people were not being achieved. Staff members told us that they lacked confidence in management and did not feel supported within their role. One staff member told us, "We need strong management." Another staff member told us, "Half the time management aren't here and when they are, they never have time to talk to us."

The inspection of Ernest Kleinwort Court raised a number of significant short-falls. People were at risk of receiving sub-optimal care and were not always receiving care that enhanced and promoted their well-being. The provider was open and honest about the concerns identified and showed dedication to the on-going improvements of the service. During the inspection, senior management team advised of the changes to the management structure to help aid communication and drive improvement. Subsequent to the inspection, the senior management team provided action plans with their intentions and steps already taken to make the desired changes to ensure good outcomes for people.

People were not protected by the provider's systems and processes to monitor the quality of the service. As a consequence of this, the provider had failed to recognise that aspects of the service had been deteriorating since our last inspection in October 2016. For example, they had failed to identify that the principles of the Mental Capacity Act 2005 were not being adhered too, people's care records were not accurate and that people were not always protected from risks associated with their care.

The provider did not have effective governance to enable them to assess, monitor and drive improvement in the quality and safety of services provided which placed people at risk. The management structure of the service was not robust in identifying shortfalls with the provision of care. The management structure consisted of two assistant managers, the registered manager, divisional manager and higher divisional management. The registered manager completed monthly audits which covered areas such as medicine management, infection control and service user participation. However, these audits failed to identify shortfalls and drive improvement. For example the service user participation audit dated February 2018 noted that MUST (malnutrition screening tool) assessments were completed on admissions and then regularly reviewed. During the inspection, we were unable to locate any pre-admission assessments or completed MUST tools. Monthly audits also failed to identify that people living with a catheter did not have risk assessments in place and people's care plans failed to holistically reflect their care needs. The provider's governance framework also failed to identify where care plans referred to the incorrect name of the individual. No checks had been made by the registered manager of people's food and fluid charts to ensure staff were completing them consistently and that people were receiving adequate nutrition and hydration.

Quality assurance and governance systems were ineffective. They failed to drive continuous improvement and promote best practice around the management of skin care, catheter care, nutrition and mental health. For example, we observed that one person's bedroom was extremely cluttered. A member of staff told us that they were living with a mental health need and experienced issues with hoarding. However, this was not reflected within their care plan and no consideration had been given to assess whether the individual was at

risk of self-neglect. One person's care plan stated that their fluid input and output should be record to ensure that their catheter was draining appropriately. Twenty four hour fluid charts were in place, yet these contained unexplained gaps and omissions. For example, on the 6 March 2018, their fluid chart documented no fluid intake and that 1000mls of fluid was drained from their catheter at 09.00am. No further documentation was noted. Lack of recording meant the provider could not demonstrate whether the person had received the necessary care or if staff had simply failed to record their actions. We found this was a consistent theme across the care documentation we reviewed.

One person's care assessment from the local authority noted a history of skin break and made reference to previous significant pressure ulcers. However, their risk assessment failed to reflect this history and noted, 'any changes should be reported to the district nurses.' Information was not available on what was meant by any changes. Another person was assessed by the district nursing team on 3 January 2018 where it was noted that they required a soft moist diet and were experiencing a moisture lesion. However, this information was not reflected within the body of their risk assessment. Care plans and risk assessments failed to holistically assess people's risk of skin breakdown and what actions were required from staff to manage the risk.

Some documentation was contradictory and unclear at times which posed a risk that staff did not have sufficient guidance to follow to provide safe care. For example, one person's care plan stated that they had a catheter in situ and required support to change the catheter leg bag weekly. However, one staff member told us that they did not have a catheter in situ. It was therefore unclear what level of support the individual required to manage their continence needs. One person's eating and drinking care plan stated that staff should be vigilant and should be aware of what to do if choking in the event of seizure. However, no guidance was available on what steps staff should do in the event of choking during a seizure. Their care documentation also included a catheter passport which reflected that a catheter was inserted during a hospital admission in February 2018. However, no catheter care plan or guidance was available on the type of catheter or whether the catheter had been removed. Daily notes dated 1 March 2018 stated that support with catheter care was provided. However, there was an absence of care documentation and assessment. A number of people's care plans made reference to choking and risk of aspiration. However, risk assessments failed to provide sufficient guidelines for staff to manage and mitigate the risk of choking. For example, one person's risk assessment noted that a person was at risk of aspiration if their head dropped forward as they not be able to breathe or lift their head up. The risk assessment stated that if there head was falling forward to wear their head strap. However, no information was provided on how to apply the head strap. This increased the risk of care not being safely monitored or provided.

A number of people's care plans included movement exercise plans. These documents were undated and it was unclear whether the exercise plan remained relevant. One person's movement exercise plan noted for the exercises to be completed daily with the support from staff. We reviewed a sample of their daily notes dating back four weeks and saw no reference to the movement exercise plan. We found this was a consistent theme across the documentation we reviewed.

The provider's governance framework failed to ensure that responsibilities were clear and quality performance and risks were not understood or managed. Staff also did not feel supported or valued in their role and told us that communication with management was not effective. One staff member told us, "We have gone to management time and time again about pressure sores and behaviours. We've done body maps and found they aren't reviewed. It's been like this for nine months; the manager says she is too busy. If you put in a complaint, everyone knows about it but there's no action." Another staff member told us, "We've got no confidence in on-call. One weekend the person on call said not to call them in the next four hours because they were going to a pantomime. Although staff meetings are quite regular but it's just for

management to say what they want. Personally I wouldn't bring anything up, you'd just get scrutinised if you did." Another staff member told us, "When you are on call at the weekend, you don't get much help from management. I was trying to get cover for shifts after staff rang in sick, which happens every weekend. I was just told 'well, someone's got to do it', which meant me ending up doing extra hours. On-call didn't offer to come in. You try and do everything, but get no thanks for it."

The providers and managements approach to quality was poor. Staff members told us how on numerous occasions they raised concerns to management around people's care only to face resistance. One staff member told us, "We continually raised concerns around one person but were told we were being paranoid and it was just the way they were. " Another staff member told us, "We support some people who were making allegations against each other. It should have been dealt with at a high level, but on shift there was no support. It shouldn't have been down to support workers to take statements from each of them. As support workers, we made a decision to arrange a meeting between them in the quiet lounge. But we were told they've argued before and it will be fine. I don't know whether things went to safeguarding, but the whole situation has deteriorated. I don't know if there are any written guidelines, nothing has been brought to my attention." Another staff member raised concerns over management over ridding their judgement to place agency staff with a person who didn't respond well to agency staff. Staff lacked supported and were not empowered to question practice and raise concerns.

Relatives also raised concerns that the service was not always proactive in meeting their loved one's care needs. For example, one person required support to go on a trip out once a week. However, their relative advised that this was not always taking place. They also commented, "They are not very proactive in identifying how they could promote (person's wellbeing). I've suggested things but they have never come forward with ideas."

Systems were in place to share information; however, these systems were not effective. A handover sheet was available each day and handovers took place between each shift. However, the handover sheet failed to share vital information about people's healthcare needs. For example, if one person's catheter became dislodged, they required urgent medical attention within the hour. However, this was not reflected on the staff handover sheet. This person also experienced a condition whereby if there was a sudden increase in their blood pressure they would be at high risk of a stroke. This vital information was not reflected on the staff handover sheet. This meant for new staff members or agency staff they would be dependent upon care staff sharing that information. One person was assessed by the district nurses on 4 March 2018 who recommended increasing toileting checks. However, this advice was not reflected on subsequent handover sheets to share that information with other staff members. We brought these concerns to the attention of the senior management team who agreed that staff handover sheets required amending to reflect key and pertinent information.

Relatives told us that their loved ones were happy at Ernest Kleinwort Court. However, they felt improvements could be made to management and communication. One relative told us, "The management structure isn't very good. If there is a management structure, I've not seen it in operation. Communication isn't very good. We've raised concerns over and over but don't always get anywhere. We need feedback on how our loved one is. We asked for staff to complete a communication diary advising on what (person) has done. It's hit and miss whether it's completed. Some services we pay for and need to know that they have taken place."

During the inspection staff members raised concerns over lack of support from management and poor staff morale. Staff members told us how they felt devalued and unable to raise concerns with management. One staff member told us of a recent challenge they faced when they were trying to support one person. They

advised that they wanted to support the person to have a scan after a history of cancer within the family but only to be told by management that they were being paranoid. Staff were therefore pushing for actions to promote people's wellbeing but were not consistently supported to do so.

Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the service. There was a failure to maintain accurate, complete and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.