Care Quality Commission

Kalbro Investments

Eleanor House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place over two days on 8 and 9 January 2015 and was unannounced.

Eleanor House is registered to provide accommodation and personal care with nursing for 17 adults who may have mental health or dementia related conditions. Accommodation is located on the ground and first floors, with both shared and single rooms. There is lift and stair access to the first floor. The service is situated close to local amenities.

There had not been a registered manager at this location since 5 November 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new acting manager had been appointed following our visit in August 2014. Whilst we found they had plans for improving the service, we found they had not yet implemented the requirements that were needed that would ensure safe and effective care was delivered.

At our last inspection on 21 August 2014 we found the registered provider was failing to have an effective system

Summary of findings

in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. We served a Warning Notice on the registered provider telling them where they were failing and requiring them to address the issues before 7 November 2014. We also asked the registered provider to make improvements to assessment and planning of care, safeguarding people who used the service from harm, maintenance of the building, staff training and development to ensure the service was compliant with regulations associated with the Health and Social Care Act 2008.

The registered provider sent us an action plan telling us the improvements they were making. During this inspection we looked to see if these improvements had been made. We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered provider had not responded effectively and promptly to our concerns; very little improvement had been made to ensure people received care that was safe, effective and protected them from harm.

We found people's safety was being compromised and they were at serious risk of harm because care was not being assessed and planned in a way which met their changing needs. An action plan had not been implemented to address the preliminary findings of an on-going safeguarding investigation. Incidents involving the management of behaviour that may challenge the service and others had not been appropriately reported and staff were unclear about their responsibilities about this. Recruitment systems were not safe. There was no system in place to assess staffing levels required to meet people's changing needs. There were insufficient numbers of staff to enable people to have access to appropriate community activities

Staff did not have the knowledge and skills they needed to carry out their role and responsibilities effectively. They were not clear about care support to prevent people sustaining pressure damage; they were also not clear about the management of a specialist feeding tube (PEG) for a person who used the service.

The human rights of people who may lack capacity to take particular decisions were not protected. Staff understanding about the use and principles of the Mental Capacity Act (MCA) 2005 was unclear. Staff were using physical interventions which had not been formally agreed which meant they could be restraining people unnecessarily and was outside the law. Staff had not received training about safe use of physical interventions.

There was no evidence of capacity assessments and best interest meetings to support consent for people who did not have capacity to make informed decisions.

Areas of the building and furnishings required renewal and repair to ensure people's safety and the appropriate standard of décor and comfort was maintained.

People we spoke with were positive about the care they received, however this was not supported by our observations and feedback from health professionals.

We were concerned some people living at the home were isolated because they did not leave their rooms regularly or at all, and there were not enough opportunities for people to engage in hobbies, social interests or activities either as a group or on an individual basis.

The culture of the service was not open and transparent with professionals who were trying to support the service, such as the local adult safeguarding team and there was a lack of reliable information to show the service was being run in the best interests of those living there.

Inspectors found that improvements required as a result of a previous inspection had not been made, and we also identified further concerns. As a result CQC is considering all options available to them in relation to protecting people who use the service.

Breaches were found in regulations 9, 10, 11, 15, 17, 18, 22 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was also a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have deemed these posed a potential significant impact on people who used the service. This is being followed up and we will report on any action when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Whilst some training had been provided about how to keep people safe from harm, staff had a poor understanding of the signs of abuse and how to respond appropriately to any allegations of abuse. The local safeguarding team had not been made aware of incidents of potential abuse between people who used the service.

Care was not always planned and delivered in a way that enabled staff to meet people's individual needs and ensure that risks to their welfare were safely managed.

The service had not regularly reviewed staffing levels to ensure people were supported to safely access the community when they requested.

Shortfalls in the security and safety of the building and equipment, meant there were risks to people's safety and welfare.

Inadequate

Is the service effective?
The service was not effective

Where a person lacked capacity they had not been subject to an assessment under the Mental Capacity Act (MCA) 2005 and best interest decisions had not been made. The Deprivation of Liberty Safeguards (DoLS) were not understood and appropriately implemented. Staff had not received training appropriate for their role. Nor had they received supervision or appraisal from their line manager.

People's needs were not always recorded accurately to ensure their health and welfare was effectively promoted.

The environment for people had not been appropriately assessed to ensure it was suitable for people with dementia related impairments.

Inadequate

Is the service caring?
The service was not always caring.

Whilst staff treated people with kindness, people's meaningful involvement in decisions about their care and support was limited, which meant their wishes and feelings may not always be met.

The personal dignity of people was not always respected for example, there were an absence of screening in some shared rooms, which meant people's privacy was not promoted.

Requires Improvement

Is the service responsive?
The service was not always responsive.

Inadequate

Summary of findings

Information about people's needs was not always accurately recorded to enable staff to support their individual wishes and feelings consistently and ensure people were protected from potential risks.

People's care files was not sufficiently developed to enable staff to be guided on their current care, treatment and support needs, which puts people at risk of inappropriate care.

Communication about people's needs were not always followed up in a timely manner to ensure they had access to appropriate support when this was required.

We observed people experienced long periods of inactivity and there were limited opportunities available for them to be meaningfully engaged in social events to enable their interests and hobbies to be promoted.

Is the service well-led?

Inadequate

The service was not well led

Appropriate action had not been taken to address the requirements of an action plan developed by the registered provider following safeguarding concerns that had been raised.

The quality and safety of the service was not being adequately monitored or reviewed. The systems in place were not effective.

Shortfalls in the service had to be pointed out by CQC, or other professionals and agencies, before action was taken to ensure the service was operating safely.

Eleanor House

Detailed findings

Background to this inspection

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

This inspection took place over two days, on 8 and 9 January 2015 and was unannounced. On the first of our visits the inspection team consisted of two social care inspectors, an inspection manager and an expert-by-experience with experience of supporting people who have mental health needs. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day a specialist professional advisor with experience of supporting people with mental health issues accompanied a social care inspector to follow up our findings.

Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However due to technical issues the registered provider was not able to return the PIR as requested.

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

We talked with four of the people who used the service, a member of the domestic staff team, three members of care staff, a qualified nurse employed by the service and the acting manager. We also reviewed information sent to us by external organisations that had an input into the home, including the fire department, the local safeguarding team and members of the local authority commissioning team. We also spoke with two community based professionals who had involvement with the home.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure when people were assessed as lacking capacity to make their own decisions, best interest meetings were held to enable important decisions to be made on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and those with people who used the service, quality assurance audits and maintenance of equipment records. We completed a tour of the premises to check if the environment was clean and safe.

Is the service safe?

Our findings

During our inspection of 21August 2014 we found not all incidents of potential abuse had been reported to either CQC or the local authority safeguarding team. We identified the registered provider did not have an effective system to record and report safeguarding incidents.

During this inspection visit we were told that safeguarding training had been provided to staff since our last visit to the home. However, we saw was evidence further work was still required about the management of physical interventions by staff and reporting of safeguarding concerns following episodes of physical aggression and management of behaviours of people who may challenge the service or others. We spoke with the acting manager and one member of the nursing staff, neither recognised when incidents had taken place that these were potential safeguarding incidents and would require further investigation and reporting to the appropriate agencies involved.

Care staff told us they completed incident forms about episodes of physical and verbal aggression between people who used the service and passed these on to the nurse or the acting manager to deal with. They told us they were not directly involved in reporting safeguarding concerns and not sure whether incidents were officially reported to the local safeguarding team and CQC when required. We asked care staff about risk assessments and care plans for people who used the service and whether they included details about the management of potential aggression. The care staff told us they thought that care plans contained some information about this, but were not sure of the details.

During discussion one member of staff explained, “We just know how to calm people down, I have worked here for 10 years so know the residents well.” We checked the records of incidents which had occurred between people who used the service. We found since the last inspection there had been three incidents which should have been discussed with the local safeguarding team but there was no record of contact with them for advice and guidance about this aspect of the service since July 2014. We were concerned that by not notifying the local safeguarding team or CQC of incidents of physical assault or allegations of abuse did not ensure that investigations were completed that would protect vulnerable people and providing advice and guidance to staff in how to manage incidents. The acting manager told us they had not recognised these as potential safeguarding incidents that should have been reported.

We saw an incident where one person had sustained bruising to their upper arms. We spoke to the acting manager about this incident and they told us staff had physically assisted this person as they were refusing to accept an element of personal care support. They described how staff had provided this support and said, “Three staff had to take hold of xxx two holding their hand and elbow and another one behind.” The acting manager then told us the staff would physically assist the person to have a shower. This form of physical intervention was potentially dangerous and unlawful as staff had not received training on its safe use. This incident was referred to the local safeguarding team for further investigation and at the point of writing this report had not concluded.

We saw evidence that a safeguarding concern was currently subject to an ongoing police investigation. We found the registered provider had met with the local safeguarding team about this, but failed to take their advice to suspend a member of trained staff implicated in this. We also found the acting manager had failed to implement an action plan developed by the registered provider in respect of the risk management of this issue. The concerns detailed above were a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

We saw procedures were in place to ensure the safe recruitment of staff to work with people who used the service, however records showed these were not always safely followed. For example, one of the three staff recruitment records we looked at showed us that a recently appointed member of staff had been dismissed from their previous two jobs. Whilst we saw Disclosure and Barring Service (DBS) checks had been carried out to ensure they were not included on a list that barred them from working with vulnerable adults and their references had been followed up, we were unable to find evidence of the decision making for the offer of employment and why this person’s previous employment had been terminated.

When we inspected the service on 21 August 2014, we found people’s care and treatment was not planned and delivered in a way that ensured risks to their safety and

Is the service safe?

welfare was promoted as information about their individual needs was not consistently maintained. The acting manager told us people's care records had been rewritten since our last visit but had been unable to find initial assessments for people when they had first commenced living in the home.

We saw that risk and behaviour management plans did not contain detail in relation to potential risks to people and were not descriptive, specific or accurately recorded, to ensure staff knew how to manage these safely. For example, we found the care file of a person with a previous history of aggressive behaviour and early onset of dementia, contained a care plan for behaviour that challenged. We saw the plan failed to document how staff should manage this behaviour.

During the inspection we spoke with the nurse in charge who had developed the care plan about whether the details for this had been based on a clinical diagnosis or information received from a healthcare professional and we were told, "No it's just what I've been told." We saw a care plan for the management of another person's mental health and 'Increasing agitation anxiousness and hallucinatory thoughts' failed to detail identified triggers and de-escalation techniques that should be used to minimise outbursts and physical attacks on staff.

We saw the accuracy of a nutritional assessment for this person lacked clarity of information about their needs and provided a recorded numerical score rating of 7, whilst information in their care plan and from discussion with staff indicated this should actually be around 13.This meant people were not protected against risks of receiving care or treatment that is inappropriate or unsafe and is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

We found there was a qualified nurse on duty at all times who was supported by two members of care staff. However, the acting manager had not regularly reviewed staffing levels to ensure there were always enough staff available to ensure people's physical, emotional and psychological needs were safely supported. The acting manager told us they did not have a tool to enable them to determine safe staffing levels in the home. We were unable to find evidence of how and when staffing levels were adjusted to enable people to receive elements of one to one support they were funded for.

Staff told us, "We don't have time to do any 1-1s with people or take people out when they want. We used to have outings and there was more going on", "I don't think there are enough staff." We saw two staff were required to support one person when in public places, to ensure their personal boundaries were appropriately maintained. We observed however their care plan failed to give details about how often they were to be supported in public and did not describe specific actions for staff to ensure the least restrictive practices were followed. We found another person was funded to receive periods of one to one support from staff. However, we were told the paperwork about this could not be found and were told by the acting manager they were uncertain about the details and frequency for this. Staff also told us it depended upon which nurse was on duty as to whether they would get involved with providing support to people. They told us, "Some (nurses) do and others don't get involved with the residents." This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

We found people's medication needs were supported by the qualified nursing staff. We observed a medication round, this was carried out in an unhurried manner, with positive support and time given to people, together with explanations provided about what their medication was for. We saw people's medication was dispensed from a trolley that was securely locked when not in use and we observed that temperature checks were maintained for medicines required to be stored under refrigeration to ensure they remained effective. We made a check of the medication records and saw that accurate records had been maintained of medicines administered to people who used the service.

One person who used the service told us, "I would like my door painting as it's scuffed."

During our last inspection of 21August 2014 we identified concerns in relation to the upkeep and safety of the building which posed a potential risk to people who used the service. We contacted the fire department about this and found they had served an action plan on the service.

Is the service safe?

The fire service said they had subsequently found improvements in relation to most of the areas of concern and were planning to make a further revisit in the near future to ensure the outstanding actions had been carried out as required. The fire department later told us they had made a further visit and had to extend the date for completion of their action plan, because the remaining work still had not been carried out.

We found the hot water in an upstairs bathroom was delivered at unsafe levels, which posed a potential scalding risk to people who used the service. This was also an issue identified on our inspection in August 2014. We saw prompt action was subsequently taken by the acting manager, with an emergency plumber called out and the room placed out of bounds until it was safe to use.

We observed the office door did not have a lock that worked and we were concerned that information about people was not securely maintained. The acting manager told us they would action this immediately.

Care staff we spoke with confirmed that rooms were cleaned on a regular basis but stated the standard of décor meant the building looked shabby and not very clean. We observed substantial work was required to improve and upgrade the building including repainting of walls, repairs to an upstairs hall way floor and replacement of items furniture and carpets that were observed to be worn. Although a maintenance programme had been developed there were no completion dates detailed and we found little evidence of improvement work carried out. In the rear garden area we found discarded equipment such as a mattress, bedrail bumpers, tools and rubbish strewn over the grass. Not only would this be a potential safety hazard for people if they chose to use this area, but it compromised the dignity of people living in the home. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

We spoke with the domestic staff who told us they considered the new acting manager was supportive of them and was trying to make changes to improve the home. We found that since our last visit the cleaning hours for the home had been increased. However, the domestic staff told us they had still to undertake infection control training to enable them to effectively carry out their role. Two care staff who we spoke with said they had completed training about infection control and the records confirmed this was the case. The care staff said there were sufficient stocks of protective equipment, such as aprons and gloves generally available. Care staff told us aprons and gloves used for personal care, were placed in white bags after their use and not in the general bins to minimise cross infection, however we observed an occasion when this had not been the case.

Care staff confirmed all bedding was changed routinely on a weekly basis and that some people's bedding was changed more regularly as required. They confirmed there was no shortages of bedding and that night staff should document this when it was changed, however we observed a person was cared for in bedding which wasn't clean and their records didn't show when the bedding had been last changed.

We saw equipment used in the home was serviced at intervals to make sure it was safe to use. On the day of the inspection we were told about a leak from the washing machine that had been noticed earlier that day which had been reported and was being repaired. Staff told us the laundry was in need of further improvement and we observed the facilities for this required a general upgrade, as there were tiles missing from the floor and wall surfaces were permeable which meant they were not easy to clean and increased the risk of poor hygiene.

Is the service effective?

Our findings

People who used the service told us staff supported them to maintain their health. One told us, "Staff are very good, they are very flexible and do anything they can to help me," whilst another person said, "They (staff) look after me very well." Despite these positive comments we identified concerns in relation to staff understanding of consent to care and the principles of the Mental Capacity Act (MCA) 2005 and support needed to prevent people sustaining pressure sores and use of specialist equipment to enable people's nutritional needs to be effectively supported.

We found staff did not always have a clear understanding of their roles and responsibilities to ensure the relevant requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This meant people's human rights were not properly protected. Care staff told us they had not had formal training about the MCA. We spoke with the acting manager who told us they were due to undertake enhanced MCA training in the near future.

We found an urgent temporary DoLS application that had been in place since November 2014 this detailed how the person was supported requiring two staff to accompany them when going out in public. The urgent DoLS application had expired and had not been renewed or followed up within the required timescale. There were no records in place to demonstrate this person's consent to continued supervision and control had been assessed under the MCA or evidence the decision for this had been made in their best interests. We saw evidence to confirm they were subject to ongoing continuous supervision and control on a regular basis. We also spoke with care staff and the acting manager who also confirmed this was the case. This meant the person had been subject to a deprivation or restriction of their liberty unlawfully.

We saw bed rails were in place for two people who used the service; however we saw risk assessments or care plans for these that had failed to consider whether their use constituted a deprivation of liberty or restriction for the people concerned. We did however see that consent to their use had been obtained and a best interest decision about them had been made involving a specialist nurse. We also found one person had been administered their medication covertly in food, however their care records indicated they did not have capacity to consent to this decision and there was no capacity assessment for this in their care file. The care plan indicated the decision for this had been made in this person's best interests by the members of their care team, although we were unable to find evidence of this, with only the documentation about it signed by the previous manager.

We found evidence the use of restraint and physical interventions was not fully understood by staff in the home. Care staff told us there weren't any restrictions placed on people and that physical restraint and interventions were not used. We asked the acting manager how people requiring assistance from staff to go outside were supported if they wanted to go out unescorted and were told staff would link arms to prevent them. The acting manager had not recognised an episode where bruising was sustained to a person following staff use of physical intervention as a restriction of the person's liberty. We saw no documentation that recorded the intervention had been formally agreed as in the person's best interest. We saw from training records and from speaking to the acting manager and care staff that training in use of physical interventions had not been undertaken by any of the staff working in the home.

The concerns identified above were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

When we inspected the service on 21 August 2014 we found people's care and treatment was not planned and delivered in a way to enable their health, safety and wellbeing to be promoted as information about their individual needs was not consistently maintained.

During this inspection we saw information about people's medical needs was recorded in their care files to enable staff to monitor their health and take action on this when needed, however we found gaps in staff knowledge around supporting people's health needs and some people's health needs were not being met safely and consistently.

We spoke with two members of care staff about their understanding of the management of people's skin integrity and prevention of pressure sores. They both advised they had not undertaken training on assessment and recording for this element of practice. They were unclear about the need to reposition people and

Is the service effective?

confirmed they would leave people for long periods if they were asleep. They were also not clear about maintaining records of skin checks and repositioning people. This meant staff may not know how to safely provide or deliver care and treatment to ensure people's wellbeing and potential risks were safely managed and promoted.

We also found the records for one person showed they had complex health needs and received their nutrition through a tube in their stomach (PEG). A community nurse practitioner told us they visited the home regularly, because they felt they needed to retain oversight of how care was delivered for this person. They explained how in recent weeks they had cause to direct staff to access specific support from a specialist PEG feed nurse in terms of the clinical management for this and care that was not taking place. The care records showed how staff had not been providing this essential care support prior to the specialist nurse visit in December 2014. Despite this direction and support from the specialist PEG nurse we found the care plan had not been updated to describe the care interventions required. Discussions with the community nurse practitioner also identified the service had run out of the feeding equipment recently and they had also directed staff on this occasion to contact the specialist PEG feed nurse to obtain the equipment.

The acting manager told us the staff had received training in PEG feeds, however records showed none of the current staff working in the home had completed this. The acting manager also told us staff showed each other and this was a satisfactory arrangement. Following the inspection we contacted the PEG specialist nurse who confirmed she would provide training for the staff at the service.

The local authority safeguarding team had recently substantiated an allegation of neglect following the admission to hospital in of a person with behaviours that challenged the service. We were told this decision was based on a failure to take prompt action by the service to involve appropriate care professional's when required, poor staff recording and communication and a lack of a comprehensive care planning and risk assessment about how staff should manage this person's behaviour. This shortfall in treatment and care meant there was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

The home is registered to provide support to people experiencing associated mental health and dementia related issues, however there was little evidence this had been positively considered in the design of the environment to enable people to feel in control of their lives and ensure their welfare was promoted. There was an absence for example; of specialist signage to help people orientate themselves around the home.

We recommend the service seeks advice and guidance from a reputable source about the design and implementation of dementia friendly environments.

When we visited on 21 August 2014 we identified limited training and support provided for staff to ensure they were appropriately equipped with the skills needed to effectively carry out their roles.

During this inspection we found little improvement had been made with the overall support that was provided to staff. We saw evidence the acting manager had developed staff training records to enable shortfalls in staff skills to be updated when required. Whilst we saw evidence in staff files of up to date certificated courses on a range of issues, we saw the new training overview record still showed significant training shortfalls in issues such as; management of aggression and behaviour that may challenge the service, dementia, end of life care, person centred approaches, staff record keeping, activity provision and clinical aspects of support such as PEG feeds and promotion of people's skin integrity. Not providing staff with appropriate training in these areas contributes to inconsistencies and potential risks associated with shortfalls in care that is delivered.

Staff told us their training involved them completing work books on a range of courses considered essential by the registered provider and then having their work assessed by an external training organisation. Both staff and the acting manager commented they felt this form of training was not the best way to learn. Two staff we spoke with said they felt their training was not effective enough and preferred to attend practical training sessions. One member of care staff said the training was, "Ok. I don't feel that I learn from some and some of it is out of date." The acting manager told us they had tried to find alternative sources of training provision. They said, "I am going to look for other training, as I don't think we should be doing all the training in this way."

Is the service effective?

The acting manager told us they had implemented a programme of supervision to ensure staff were supported to effectively carry out their roles but that more work on this was still needed. The acting manager told us they had not undertaken competency checks of a qualified member of staff to enable them to have reassurance about their professional skills and abilities, despite this being required by the home's own action plan in response to an on-going safeguarding issue. The acting manager also told us they had extended the probationary period of a newly recruited nurse following concerns noted about aspects of their practice. We found the acting manager had held a meeting with this member of staff to discuss their performance and the support that was provided by them. However, we found some recording and decision making was poor, judgemental and oppressive and discussed our findings with the acting manager, who acknowledged this and agreed with our finding. They also gave us assurances that the concerns highlighted would be dealt with immediately.

We asked care staff about support that was given to them. The domestic staff and one member of care staff said they had met with the new acting manager to enable them to be clear about their roles and enable professional direction to be provided. However, two other care staff told us they could not remember when they last had supervision about their work and we saw evidence of this in their records. We asked the acting manager about plans to ensure staff knowledge and skills were kept up to date and able to develop their careers. They said they were planning to introduce a programme of appraisals but had not had time to implement this yet. All of this was a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

We found people were supported to have sufficient variety of food and drink to enable them to enjoy a balanced diet. Everyone we spoke with said their meals were of a good standard.Comments from people included; "Pork is nice today, I like the mash" and "It tastes good." We observed the lunch time meal looked appetising and well presented, with a variety of fresh vegetables provided. People were offered other choices if they did not want what was served. We observed one person was promptly provided with a different option when they requested an alternative choice of meal and we saw another who declined to eat was given a milkshake to enable their nutritional needs to be met. Throughout the day we observed that drinks were provided to ensure people were not dehydrated and that assistance was offered to those requiring support from staff in a sensitive and friendly way. We saw one person's care plan detailed the support they required to minimise potential risks from choking. We saw a soft diet was provided to them at lunch, and during the meal care staff sat next to them to closely monitor and provide encouragement and support where necessary.

Is the service caring?

Our findings

People who used the service said that staff were kind. One person told us, "It's good here, I like the staff. " Another person said "I've no complaints, the staff see to everything for me" and another person told us, "Staff are okay." However, we found some shortfalls in how care and support was delivered.

We saw care staff demonstrated a friendly and caring approach and interacted positively with people who used the service. We observed the atmosphere in the home was open and warm. We saw care staff demonstrated kindness and patience in their approach and showed a regard for people's wellbeing. We observed people appeared comfortable in staff company and saw that

staff appeared to know them well and spoke with them in a calm and respectful manner.

There was evidence people's wishes for privacy were respected by staff and we observed personal care was provided to people discretely behind closed doors. However, we found a number of people who used the service were accommodated in shared rooms but found an absence of adequate screening available in some of these to ensure people's personal dignity was promoted and respected. Whilst we saw that an action plan had been developed to upgrade the home we did not see that improvements about this had been included.

We found information in people's care records that demonstrated limited active involvement with them about the planning and delivery of their support, to enable their wishes and feelings to be promoted in a meaningful way. Whilst we saw people's care files contained personal profiles that detailed information about their past history, individual strengths, needs and interests, there was evidence these should be further improved to enable a more personalised service to be delivered and support to be provided that maximised their independence and wellbeing. We saw for example care plans for two people who were nursed in bed that failed to document their personal wishes for things like gender support, times for personal care delivery, or preferences of clothes to enable their personal dignity to be maximised and respected.

The acting manager and care staff could not tell us how people with more complex needs were supported to express their views and experiences, or be involved in their care and support. There were no records of review meetings. There were no triggers or arrangements for independent advocates to support people with making decisions. Without this support staff were unable to ensure that as far as possible people's views were sought, listened to and acted on.

Care staff told us that some females who used the service used to receive regular support from a beautician and this had helped with their confidence. The care staff also said that during the last six months this had not taken place and that they were not aware of the reason for this.

We observed some people's clothing were not ironed properly; one person's trousers were very creased. This did not promote people's dignity. When we spoke with care staff about this issue they acknowledged there was a problem with the laundry and that some people were also short of clothing as their key workers had not purchased new items recently.

We also observed there were missed opportunities for staff to interact with people who used the service. Staff frequently walked through the lounge to the dining room without acknowledging people sitting in the lounge. There were times when staff would be sitting with people in the lounge watching TV and not interacting with them. Two people who used the service were cared for in bed during the inspection visits; whilst we saw staff provided these people with personal care support and support with meals, drinks and enteral feed, we found that other than on those occasions we did not see staff spending time with them and that they spent long periods of time on their own. All of the above represents a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

Is the service responsive?

Our findings

People who used the service told us they had no complaints about the service and that they had, "No worries." One person told us, "I don't have any problems at all." Other comments from people included, "We can please ourselves what we do, we don't get out much" and "I go to bed after we've had some supper, but you can go anytime." However, during the inspection we saw that people were not always able to undertake activities when they chose to and the support and care was not always offered in a timely way.

We saw evidence in people's care files of limited active involvement with them about their personal choices to enable staff to support their personal wellbeing and promote their independence.

We found that people's needs were not fully assessed and care was not planned and documented thoroughly. The acting manager confirmed all the care plans had been rewritten. However, assessments of people's current needs had not been carried out which meant this information was not available to inform their care and support plans. The majority of care files seen did not contain any historic general assessment records and rather than complete a new record the acting manager had put in place a disclaimer style statement in the records which detailed there was no assessment record available.

Risk management of people's needs was inconsistent. We found some people's records did not contain risk assessments for important care issues such as use of bed rails and risk of pressure damage. We saw evidence that information in people's care files was not sufficiently developed to enable staff to be guided on their current care, treatment and support needs, which puts people at risk of inappropriate care. We found examples of risk assessment records that had not been updated when the person's health had deteriorated and records which were inaccurate. For example one person's nutritional risk assessment had been completed in August 2014 and although they had experienced recent illness, hospital admission and significant weight loss their nutritional risk assessment had not been updated. Similarly this person's risk assessment for choking this had not been updated to reflect their need of a soft diet. An assessment of their risk of sustaining pressure damage had not been developed although they had high needs in this area and staff described how the person's skin discoloured when they lay in the same position in bed.

We found the care plans were generic and did not provide individual information and clear guidance for staff in how to support the person. For example, records showed one person had pressure damage and another person had sustained this in the past. The care plans to prevent skin damage for both people detailed they needed regular turns, but did not specify how regular staff should provide this support. Staff we spoke to about this gave us different time frames for the repositioning support they provided. The repositioning records for the person who had experienced skin damage in the past showed significant gaps in care support. There were no records to show support with repositioning or skin checks for the person who had skin damage.

One person's care plan to support their deteriorating mental health described their increasing agitation and anxiousness. However, this did not provide any information about the person's increased verbal communication and direct staff on how to manage this behaviour. The person's daily records contained frequent records of how vocal they had been, for example, "Started screaming and has been most of the shift." The lack of information in care plans, and on occasion inaccurate information in care plans and risk assessments, meant there was a risk important care could be missed and people may not receive all the care and support they required.

Whilst we saw evidence of communication with community professionals to enable concerns to be raised concerning changes in people's health and welfare needs, we saw evidence staff had not always followed up issues in a timely manner. The file of a person nursed in bed contained evidence of missed hospital follow up appointments that had led to a decision further treatment was no longer required. We were unable to find evidence of arrangements made to support this person to attend their appointments and found subsequent concerns had been raised by the acting manager making a request for a community physiotherapist assessment, due to episodes of severe pain experienced by this person. Whilst we saw evidence of a GP

Is the service responsive?

letter to query the reason for this referral, we found the physiotherapy assessment for this person had not yet occurred, although we were told a nurse had phoned the GP surgery to confirm this was still required.

Staff told us about a chair used to support a person who was currently nursed in bed that was unsafe as they had slipped out of it on occasions in the past. The acting manager told us they had made a request for a replacement for this but we were unable to find evidence of this being followed up. These shortfalls in care planning and assessment of people meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see the action we have told the registered provider to take at the end of this report.

Whilst we saw staff engaging with people in conversations about their lives we observed limited opportunities were available for people to be involved in any form of meaningful activity and enable their independence and wellbeing to be promoted. We saw for example the majority of people sitting for long periods of time watching television with little positive interaction provided from care or nursing staff. Whilst we observed some occasions when individual staff spent time playing dominoes with people and two people went out to a local day centre on the days of our visits, one person said they never came out of their room and had only their television to keep them company and no other options or opportunities were offered. We were told events such as barbeques were held on an occasional basis but were unable to see evidence of a regular programme for this, with no dedicated member of staff responsible for this aspect of the home.

When we looked at care records we saw evidence of judgemental and unprofessional approach to recording that demonstrated a lack of consideration for people's needs. We saw a qualified member of nursing staff had documented in a person's care file that they had been "rebuked for their inappropriate behaviour." When we spoke with the acting manager about this, they confirmed they had previously spoken to the member of nursing staff about their judgemental approach and recording. They told us they had previously talked with the member of staff about this, however this had not been addressed as the inappropriate use of oppressive language had continued.

A complaints procedure was available to ensure the concerns of people who used the service could be raised. People who used the service told us they were happy with the service they received and felt that action would be taken if they had any concerns and that they were listened to. They also told us they would talk to staff or the acting manager if they had any issues. We saw evidence the acting manager investigated complaints and followed these up to enable issues to be resolved where this was possible.

Is the service well-led?

Our findings

During our last inspection on 21 August 2014 we found the registered provider was failing to have effective and robust systems in place to monitor and review the safety and quality of the service. We served a warning notice telling them where they were failing and requiring them to address the issues by 7 November 2014. We also referred our concerns to the local authority safeguarding team who are responsible for ensuring people receiving care are safe and to the clinical commissioning group (CCG) who fund the placements for some of the people who live in the home. The registered provider sent us a plan of how they were going to improve the service and also confirmed work to implement the action plan was underway.

A new acting manager had been appointed since our last inspection visit on 21 August 2014; however we found they had not yet submitted an application to be registered to manage the home. They told us they received regular visits from the registered provider and said, "I email them and he's always on the end of the phone, I have no problems and he is supportive." Whilst staff told us the acting manager listened and took an interest in what mattered to people and the domestic staff told us their hours had increased, care staff also told us they had not yet seen much improvement in the home.

The registered provider is required to send the Care Quality Commission (CQC) notifications of incidents affecting the safety and wellbeing of people who used the service. We found three incidents in September and October 2014 when episodes of challenging and aggressive behaviour between service users had not been recognised as potential abuse and not reported to the Care Quality Commission and local authority safeguarding team.

Whilst similar issues were identified at our last inspection, the acting manager did not appear to acknowledge the potential seriousness of this, which raised concerns the culture of the service may not be open and positive to improving for the benefit of people living at the home.

Whilst the acting manager told us they would make themselves familiar with the requirements regarding notifications of incidents, we found they had failed to implement the home's own safeguarding action plan to enable the service to improve and had not taken the opportunity to learn from incidents or safeguarding investigations.

Notifying the CQC of incidents which affect the health and welfare of people who use the service enables us to check how these are being dealt with. The fact the registered provider had not made the required notifications following these incidents demonstrated concerns about the effectiveness of the quality monitoring system and was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The acting manager told us there was no system currently in place to review staffing levels to ensure there were enough staff available to meet service users' needs and respond to changes in their needs and have access to appropriate social activities. We found no evidence of how and when staffing levels were adjusted to enable people to receive elements of one to one support they were funded for. We found for example; two staff were needed to support one person when in public places, to ensure their personal boundaries were safely maintained, but observed their care plan failed to provide details about how often this support was to be provided. We saw no paperwork was available for another person who was funded to receive periods of one to one support and the acting manager told us they were uncertain about details and the frequency for this. Staff told us, "We don't have time to do any 1-1s with people or take people out when they want. We used to have outings and there was more going on", "I don't think there are enough staff."

Whilst we saw meetings took place with staff, there was also evidence communication with them was not always good and that staff did not have a clear understanding of their professional roles and responsibilities. Care staff told us they didn't feel all of the staff worked as a team, but confirmed care staff did support each other. One member of care staff told us, "I don't feel we work well together, nurses don't get involved."

We saw a programme of supervision had been introduced to enable staff to be supported and understand what was expected of them, but found this had not been effectively implemented and that staff skills had not been appraised. We saw evidence of significant shortfalls in a range of training that meant there were gaps in staff knowledge and skills to support people safely and ensure they were

Is the service well-led?

protected from potential harm. Two staff we spoke with said they felt their training was not effective enough and preferred to attend practical training sessions. The acting manager told us "I am going to look for other training, as I don't think we should be doing all the training in this way."

Staff, including the acting manager's understanding about the use and principles of the Mental Capacity Act (MCA) 2005 and DoLS was poor. Staff were using physical interventions which had not been formally agreed and meant people may be restrained unnecessarily and was outside the law. Staff had also not received training about safe use of physical interventions. Staff were unclear about care support that was required to prevent people sustaining pressure damage; they were also unclear about the management of a specialist feeding tube (PEG) for a person who used the service.

Although a system had been introduced to enable the quality and safety of the service to be monitored, we saw this had failed to identify shortfalls and recognise issues that placed people who used the service at risk of potential harm. There was evidence that audits had not always been carried out in a meaningful way to enable the service to improve. We saw audits of incidents involving episodes of challenging behaviour of people had failed to identify when these should have been reported and enable them to be investigated. We found the record of incidents showed no evidence of analysis or debrief of these, or that action plans had been developed for these to enable future incidents to be minimised and enable the service to develop.

Audits of service users care plans had failed to ensure people's care needs were accurately assessed and monitored to enable their care planning to be kept up to date.

We also saw that audits of the environment had failed to identify improvements to the safety of the building that were needed or dates when an action plan for this would be completed, which placed people at risk of potential harm.

We found that incident reporting systems were not being used effectively. This meant that opportunities for improving the care being delivered were lost, as lessons were not being learnt. We saw for example a falls audit indicated a person had experienced 11 falls since 17 September 2014. Whilst we were told by the acting manager this had been reported to the falls team, we were unable to find evidence this had been followed up and acted on.

Whilst we saw evidence that meetings were held to enable people who used the service to contribute ideas and suggestions about the home we found these were not taking place on a regular planned way. We saw evidence the acting manager had recently undertaken surveys of people's views to enable them to share feedback about developments for the home but found an action plan for this had not yet been developed to enable issues highlighted to be addressed. All of the above demonstrated a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.