Eleanor Nursing and Social Care Limited

York House and Aldersmore

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 over three days: 23 May 2017 and 1 June 2017, which was unannounced, and 24 May 2017, which was announced.

York House and Aldersmore provide personal care and support for up to 18 people who have a learning disability or autistic spectrum disorder. People who use the service may also be living with mental health needs, a physical disability or dementia. At the time of our inspection there were 16 people living in the service.

In March 2015 we found the service to be good in all key areas and rated the service as Good overall. However we recieved information from local authority safeguarding and quality monitoring teams about the management and care practices which identified the quality of the service had deteriorated. Therefore we carried out an unannounced focused on the 18 March 2016 and looked at two key areas: Safe and Well-Led. We rated Safe as Requires Improvement and Well-led as Inadequate. Multiple breaches of legal requirements were found. These related to the safety and cleanliness of the environment, care being provided in a routine and regimented manner, and governance. You can read the report from our focused inspection on 18 March 2016 by selecting the 'all reports' link for 'York House and Aldersmore' on our website at www.cqc.org.uk

Following that inspection the provider sent us an action plan to tell us what improvements they were going to make, and stated the work would be completed by December 2016. During this inspection we found some improvements had been made. However, the oversight of management was still failing to effectively identify, manage and embed systems to ensure the quality and safety of the service. This resulted in new and ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. These breaches were in relation to staffing, safe care and treatment, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of this report.

There was no registered manager in post as the previous registered manager had left the service in February 2017. Action was being taken by the provider to recruit to this position. 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. At the time of the inspection, a registered manager from one of the provider's other services was on site, providing management support.

In February and March 2017 we became aware through information we received from multiple sources of concerns relating to the culture and leadership of the service. This included that the improvements referred to in the provider's action plan had either not been embedded fully or where deteriorating further. This inspection confirmed that the service quality had deteriorated and that the provider had failed to take effective action to intervene or prevent its occurrence.

The systems in place to reduce risks associated with people's care and support were not always in place, effective or fully explored. This included risks associated with fire safety, physical and mental health needs, environment, mobility, nutrition and support from effects of anxiety and stress were not always being identified or effectively managed. Staff were not being given enough guidance, information and training to proactively identify and take action to minimise any potential risks. Care records provided insufficient guidance for staff in providing safe care and in supporting people's wellbeing.

Whilst some action had been taken to improve the environment and cleanliness, this was not applied to the whole service which meant improvements were not always sustained and other risk areas had not been proactively identified and dealt with. Provider audits and governance was not robust enough to manage this and ensure results were achieved and sustained.

Some improvements had been made in breaking down 'institutional' routines, but work was still ongoing in this area. This led to many people experiencing very different levels of quality in the care provided. Staff were not keeping updated on what 'Good practice' looks like. Training did not reflect the levels of competency and skills needed to support the identified needs of people, some of whom were living with very complex needs. This included having sufficient staff over the 24 hour period to ensure any routines were person, and not staff and/or task led.

People, their relative's, health and social care professional's feedback that the quality of care and interactions with leadership and staff varied greatly. Some provided examples where staff demonstrated a compassionate and caring approach. However others shared serious concerns about how people were not always provided with consistently kind and caring support. Some described this as different depending on which staff were on duty. There were examples where individuals interests and preferences where not explored or fully considered. Risk assessments and care planning was not detailed enough to demonstrate that people's needs were understood and met. Further work was needed to ensure people's care records demonstrated how they were being supported to have access to fulfilling and purposeful everyday lives.

Development of care did not always consider how to involve people more through the use of new or innovative models of care, technology and/or best practice guidance. This included care records that were in a format that met individual's communication needs. The service supported people, whose mental age may not reflect their physical age, people living with dementia and those with sensory loss. All of which can impact on their ability to communicate and have their voice heard. We have made a recommendation around the use of communication aids to support people in this area.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. We have made a recommendation to support the staff in developing their working knowledge around the use of best interest decisions to ensure they always follow correct procedures.

The service had systems in place to support people with their medicines as prescribed. Improvements were needed in the safe storage and record keeping including staff completing records accurately to confirm the level of support they have given. Improvements were needed in monitoring for signs of where people were at risk of being over / underweight, and in encouraging diets to support their health needs.

The provider had failed to make necessary improvements and prevent further deterioration in the quality of service because of a lack of robust and accurate systems of oversight and governance. The service has been rated Inadequate in Well-led for over a year and has not had the necessary resources or input to ensure a timely turn around and improvement for the people using the service.

Following the inspection we met with the provider's representatives including the Director of Eleanor Nursing and Social Care Limited. This enabled them to tell us the plans they had started to implement and those which were being worked on to address our concerns. They were committed to driving continuous improvements for those in their care. CQC is now considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed to ensure any risks to people safety and welfare were identified and acted on.

Medication was not being managed safely. People were not always being provided with a clean and well maintained environment.

Staffing levels were not sufficient to meet people's needs safely and to provide a safe environment.

Is the service effective?

Inadequate

The service was not effective.

We found staff were not receiving adequate training and support to ensure they had the knowledge and skills they needed to carry out their roles and responsibilities.

Not all people were being effectively monitored and supported by staff to ensure they were given a balanced diet to support their health and welfare.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support. Improvements were needed to risks associated with people's health needs were identified and ensure guidance from other professionals was followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Improvements were needed to ensure all staff's interactions were respectful, caring and compassionate so all people felt listened to and valued.

People's independence was not always being promoted.

People were not always provided with information that met their

communications needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had been revised but did not provide clear guidance for staff on meeting people's needs.

Improvements were needed to ensure all people had access to stimulating occupation / activities, linked to latest research, which met their individual needs.

Complaints procedures were in place and displayed.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance, oversight and leadership of the service were not robust enough to independently pick up shortfalls and act on them.

Improvements were needed in promoting an open culture where people are being kept updated on what is happening in the service and share their views.

Improvements were needed in the leadership's knowledge of the specialist services they are providing. This is to ensure they are keeping updated in latest research and best practice as part of driving continuous improvement

York House and Aldersmore

Detailed findings

Background to this inspection

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

This inspection was undertaken buy one inspector and took place over three days: 23 May 2017 and 1 June 2017, which were unannounced, and 24 May 2017, which was announced.

Before our 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 information we had received about the service such as the provider's improvement plan and notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

During the inspection we spoke with three people about their views of living at the service. Where people were unable speak with us directly we used informal observations to evaluate their experiences and help us assess how their needs were being met. We also observed how staff interacted with people. We spoke with seven people's relatives, community nurse, best interest assessor and social care professional.

We looked at records in relation to five people's care. We spoke with the interim manager, two operations managers, quality assurance manager, and eight members of staff including, senior support workers, care workers, one to one support workers and domestic staff. We looked at records relating to the management of the service, staff recruitment and training, medicines management, complaints and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our last inspection of 18 March 2016 found a breach of Regulation 9 (Person centred care) and Regulation 15 (Premises and equipment) of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because we found areas of risk where people's care and support was being provided in a routine and regimented manner. In addition the environment was not being kept sufficiently clean and well maintained. The provider wrote to us and told us about the improvements they had made.

At this inspection improvements were still needed. Relatives spoke about the vulnerability of people and the risks associated where people are unable to communicate effectively any concerns. We found people, and where applicable their relatives, were not being supported in understanding what keeping safe and good practice looked like, or what action to take to report concerns. Without this there is a potential that risks won't be recognised or reported and the opportunity to take action is not taken to protect people. Relatives also shared that this was also linked to their concerns about effective communication with the management team and lack of contact from the provider.

Risk assessment was not robust enough to ensure there were agreed and effective plans in place to support people whose anxiety could place them at risk of harm. One relative observed how people living together as part of a 'large family unit' picked up on the anxieties of others, including staff. Two relatives noted indications that the person they visited was anxious and recognised signs of potential self-harming. They felt that the sudden changes in management, high turnover of staff and lack of communication from the provider wasn't helping to relieve people's anxieties. One relative said "[person] doesn't like change," and a lot had been happening. Risk assessments did not reflect the impact of change on people's wellbeing. In addition they did not assess the impact of anxiety on others using the service. We found that not all incidents involving the safety and welfare of people were being documented by staff. There was no accurate information to check the number of incidents associated with people's anxiety or, what action had been taken to reduce the risk of it happening again.

The minutes of the March 2017 staff meeting showed that behaviour management strategies had been discussed for a person displaying 'more challenging and dangerous behaviours'. As a result staff were required to protect themselves and others in such circumstances. We observed a member of the visiting leadership team intervening in one incident. They were able to support staff. However, records and discussions with staff showed that they had not received safe physical intervention training. They were therefore unable to demonstrate how the situation would have been managed if the visiting manager had not been there.

This inspection identified shortfalls in the oversight, training and staffing levels which all impacted on the service's ability to identify and manage risk. This put people at potential risk where risks associated with their individual safety, support and health needs were not being identified and / or acted on. For example there was no risk assessment associated with indwelling catheters to ensure staff took appropriate action to prevent the risk of trauma and knew how to recognise associated infections or potential problems for those who used them.

The provider had written and told us they had taken 'immediate' action, to address the concerns raised during our inspection of March 2016 relating to the environment. This included putting in a 'robust cleaning and maintenance action plan' and referenced communal bathrooms being 'deep cleaned' and 'thorough' checks of the premises. The action plan also stated the 'general state of repair is excellent'. This inspection showed that the service continued to have shortfalls in this area.

A relative felt there had been some improvements in the cleanliness of the service but felt more work was required, "Bathroom areas that concern me." We saw dusty / dirty toilet frame seat, wheelchairs, bathroom floor and pull cords. Mop heads were being stored wet, instead of being air dried to prevent the risk of bacteria growing. Paper towels were not being replenished as soon as they ran out, as part of ensuring staff followed safe hand hygiene procedures. Food was being stored uncovered in the fridge, there were opened food containers which had gone past their expiry date, and items not dated to show when they had been opened, and or, given a use by date. This put people at risk from potential cross contamination, and effects of eating food which had gone off. We also saw broken fire door releases, uneven decking in the garden and floor seals (potential trip hazards).

Staff were not being given safe guidance on the use of mobility equipment to ensure people were assisted with transfers in a safe manner. There were also no effective risk assessments in place for the use of bedrails, monitoring nutrition, skin viability and supporting behaviours that challenge and could impact on the safety and welfare of others.

Improvements were needed in the management of medicines. Where people were supplied as required medicines, referred to as PRN, there was no clear guidance to support staff when they should be used, and in monitoring their effectiveness. We found 'gaps' in people's medicines administration records (MAR). This identified that staff were not always signing the records after the medicines had been administered, or if not, recording the reason why.

The use of body maps and cream charts, needed to be explored further to ensure they provided staff with clear guidance on the prescribed use, and how the staff member applied and recorded this. Where people were unable to communicate they were in pain there were no pain assessment tools being used to support staff in recognising when pain relief may be needed.

We observed part of the lunch time medicines round. On two occasions the medicine trolley was left unattended with the keys in the closed door. This included when the staff member left the dining room. Although there were other staff in the facility, they were preoccupied supporting others. There was the potential risk that a person could inappropriately gain access to the medicines, or remove the keys. We pointed this out and the staff member locked it and took the keys with them.

The shortfalls we found in medicines, as well as safeguarding people's welfare, risk management, fire precautions, maintenance, infection control all impacted on the service's ability to ensure people were being provided with safe, good quality care and treatment.

The interim management and leadership team took action during the inspection to start addressing the shortfalls. However we were concerned that these issues had not been independently identified and actioned prior to our inspection.

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

The management team were unable to demonstrate systems in place for regular review of staffing levels

based on the needs of people using the service. A visiting professional told us that they felt that the service was, "Running on minimal staff". They said the impact of this was a lack of flexibility to enable people to go out when they chose because two staff members were assessed as needing to support this.

Because there was no analysis or information on how staff were being used, we were concerned that there was not enough staff deployed to ensure people's needs were being met. Our observations supported this. In addition to care staff working between 7am and 9.15pm there were separate support staff for one to one care, activities and domestic/cooking responsibilities. However this number decreased at weekends and cooking people's meals, domestic and maintenance tasks were being covered by care staff. As described in this report we found shortfalls in these areas which had not been identified as potential risks for people, staff or visitors using the service.

On each of our inspection days, we saw there were not enough staff to provide safe, personalised care in a timely manner. A staff member said there were not enough staff as they were trying to prepare the evening meal, support people who required two staff to assist with their personal hygiene and support people with were anxious and needed support to feel better and protect from risk of harm. Staff were assisted where able, by the visiting leadership and interim manager, but when not on the premises staff would be expected to manage on their own.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we remained concerned about staff ability to recognise risk and take action, staff told us they would report any concerns about poor practice to the management. One staff member said, "I wouldn't think twice about reporting any concerns…they [people] are so vulnerable, got to be vigilant." Since the last inspection the provider was able to demonstrate that where a safeguarding concern had been raised and investigated, records were in place showing actions had been taken through reflective learning, disciplinary action, and putting more robust checks in place.

Recruitment checks being carried out to assess staff suitability to work with vulnerable people had been reviewed; however we still found some errors to the process. For example gaps in employment history which had not been explored and acceptance of checks from the Disclosure and Barring Service (DBS) from a previous employer. There was no information or risk assessment to explain why a new up to date one had not been applied for by the new employer (the provider). This showed that the system introduced following our last inspection had not fully been embedded to ensure safe recruitment.

Inadequate

Is the service effective?

Our findings

We found staff were not receiving adequate or appropriate training and support to ensure they had the knowledge and skills to carry out their roles and responsibilities. This put people at risk of not receiving safe, effective care and support which is based on best practice. The provider's website stated they 'provide specialist residential care for people with learning disabilities, including autistic spectrum disorders, and high care needs'. Discussions with relatives, information received on the Care Quality Commission (CQC) website, and training records did not demonstrate that staff had the training which reflected this statement.

Relatives told us the service was not always meeting their expectations because staff did not all understand how people needed to be cared for. They spoke about lack of understanding about how to communicate effectively, encouraging skills and new experiences. One relative told us, they felt staff needed to be more, "Active listeners…talk, listen and support…not just do it because is it quicker." We observed staff were not taking opportunities to fully involve people in routines of daily living. For example, wiping down the table after lunch. A relative told us the skills required in being able to break down a task to fit the person's level of capability were not happening at the service.

Another relative told us about staff who could not effectively communicate. This caused the person to become frustrated and impacted on their well-being. They gave examples of how phrasing questions in particular ways had not promoted their relative's choice, or demonstrate understanding of the person's communication needs.

Relative told us they wanted a, "Stable staff group," who had a, "Good solid induction," as they felt this was not happening. The provider's own policy stated that staff should 'only undertake duties if they have been deemed competent to do so following suitable instruction and training'. However we found this was not happening. Examples included a staff member whose key role included infection control and handling cleaning fluids, but they had not undertaken formal training in these areas. Nor, had they completed training in other 'high risk' areas associated with their role. This included health and safety, fire safety, and safeguarding.

A new staff member, who was involved in assisting people to move safely, had not completed practical training. Instead they had watched / assisted other staff first. As risk assessments were not in place, this meant that there was no guidance to refer to, to ensure they were using the correct equipment consistently and in a safe manner. Without formal training, and checks made on staff's competency, there is a potential risk that unsafe practices are not identified. This puts both the people being supported and staff at potential risk or injury / harm.

Training information sent to us by the provider on the 9 June 2017, showed that two of the three new staff names were not included in the records. The third staff member had no training recorded next to their name. Staff told us that they were required to complete unpaid E-learning training in their own time. This was confirmed in the minutes of the March 2017 staff meeting. Where senior management told us that there were facilities so staff could complete this in work time, a staff member told us they, "Didn't have the time."

We found there were no effective systems or oversight in place to ensure staff had completed their training.

The provider had not checked to see if training people had undertaken was effective. Examples included a diabetic risk assessment which lacked detail to provide staff clear guideline associated with diabetes, and what actions to take if they were showing signs of ill health, linked to their condition.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we had received information that people were not being supported to ensure they had plenty to eat and drink. Therefore we looked at how this was being monitored. We found a lot of gaps in people's daily records where staff were asked to provide this information. It was therefore not always possible for staff to demonstrate what people had or had not had to eat or drink.

The manager and staff were able to tell us about how they supported a person who was on insulin to control their diabetes. Where the person had declined food, there was no guidance being given to staff to support them in trying different ways to encourage and offer nutritious snacks. This could have supported the person in stabilising their blood glucose levels. This had been a problem as records showed where a health professional had to intervene when glucose levels were too low.

Another person's record showed that they had been weighed twice in 13 weeks and had lost 11lbs in this time. The 'weight record' had no information on the person's height and weight to support staff in identifying if losing this amount of weight put them at any risk. The record showed that an 'N' had been written in the 'Referral Y/N' column. This indicated that the staff member completing it did not view a referral to a dietitian was needed. There was no assessment tool being used to support staff in identifying where people were at risk of being under, or overweight which could impact on their health and welfare.

When the previous registered manager had been asked by a Commissioner why they did not use a nutritional assessment tool, they had said it wasn't required due to the needs of the people they were supporting. Our findings disagreed with this statement and shows training and best practice in this area was lacking. Given the age range, mental, medical and physical health needs of the people living in the service measures were needed to identify and reduce potential risks. Records showed that staff did not receive any formal training in the management of diabetes and nutrition.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these shortfalls none of the relatives or visiting professionals raised any concerns in this area. Two people's relatives wanted to understand more about how staff were supporting people to eat a healthy balanced diet. Another had linked a person's weight loss as a sign they were unhappy but said they were pleased to see they had recently started to put weight on again. As the weather was hot during our inspection, we saw staff providing and encouraging people to drink more fluids to reduce the risks of dehydration.

One person who was finishing their meal, told us they enjoyed their food, another spoke about their favourite foods, especially those they viewed as the old fashion favourites such as, "Apple pie." Staff told us that meal times were flexible around the person's routines, normally there were, "No set time for breakfast, serve lunch about 1pm and tea time around 6pm." We saw this to be the case.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We were made aware by the interim manager that they had identified some practices in the service which did not follow best practice guidelines when considering if decisions were in people's best interests or not. They told us how they were actively investigating these cases and in one had reversed a decision where a person was being restricted without the proper assessments, involvement with them/their relatives and other professionals. The interim manager understood when applications should be made and the requirements relating to MCA and DoLS and was clear about ensuring action was taken on any historic decisions which did not meet the requirements.
At the time of our inspection there was on application under DoLS being assessed. Where an authorisation had been recently been made, the changes in management had led to an oversight of notifying the Commission, which they said they would address straight away.

Records showed that not all staff had received training in MCA and DoLS and practice could be inconsistent. For example one staff member was able to tell us in great detail about a best interest decision that may be needed and why. However feedback from others showed that staff were not always sure of what to do in practice. For example a person's food choices were being restricted to ensure that they didn't eat too much 'junk' food. This was linked to an assessed need.
Staff were unsure what to do if the person was making a choice to eat as much as they liked, or if they should be proactively stopping them. This dilemma demonstrated a need for the staff team to explore this area more fully and have detailed plans in place to support them in this area; to ensure people are having their needs met.

We recommend that the service use a reputable resource such as MENCAP and the British Institute of Learning Disabilities to support staff in developing their knowledge of when best interest decisions should be used and how to implement within the guidance of the MCA.

Requires Improvement

Is the service caring?

Our findings

Feedback we received from people, relatives and through the Care Quality Commission (CQC) website showed that not all members of the staffing team demonstrated that they were intuitively caring, or showed the same enthusiasm for their role as others. This impacted on the quality of care people received. Some described a culture did not treat people equally and this depended on who they were, who they got on with or whether or not they did what they were told. Examples also included people being excluded from social events without good cause and being spoken to in an insensitive way that did not make them feel valued. This led to two extreme views; one where people were happy and complimentary about staff and another where significant concerns were identified about staff behaviours and attitudes.

One relative told us that staff are, "Very friendly, do seem caring," Another described how the person had, "Really bonded, got a mentor…never been the case in the past." However another felt the service needed to ensure they employed staff, "Who show an interest in the clients" A visitor told us "It's seems certain members of staff care loads but others have the can't be bothered attitude."

When we visited a person in their bedroom, we saw that they had stripped their bed which exposed a stained mattress. Staff confirmed that the mattress had been supplied new, but had deteriorated. To ensure people's dignity, consideration should be given as to the quality of the mattress, linked to people's needs, to ensure it can be kept clean, and replaced when needed.

This situation had impacted on the development of positive caring relationships, supportive of ensuring people' voice is being heard. However some had observed some recent improvements. One relative spoke about the interim managers and told us they had, "Tried to open it up," and build up a repore with relatives. The interim manager was able to demonstrate to us how they would continue this work and promote good practice, equality and fairness across the service.

Whilst meetings were in place for people using the service to feedback and comment on the way their care was provided, this was very minimal. There was no exploration of other ways to engage people and involve them as much as possible. The provider had not considered how assistive technology or research on new approaches could be used and encouraged to provide greater support for individuals to become more involved. A relative told us that they felt those who, "Were more able," should be supported "With skills of daily living," Another relative felt the staff did not have the time or skills to support people in this way.

The provider states on their website 'many of the rooms within the home, like the kitchens and laundry rooms are used to help develop resident's practical independent living skills so that their dependency on support workers is reduced over time'. People's care records did not reflect this. The leadership team acknowledged that further work was required in this area, and discussed ways that they were looking to encourage this through more focused individual activity plans, and raising staff's awareness through training.

We recommend the provider explores reputable sources to support them in developing a service which

imbeds, promotes and celebrates a positive culture which supports people's individual needs and independence. For example though exploring best practice, engaging with professionals and/or others.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection of 18 March 2016 found a breach of Regulation 9 (Person centred care) this was where people's care plans did not reflect their personal preferences. The provider wrote to us and told us about the improvements they had made. Since we inspected in March 2016, the service had put new care plans in place. Although there were elements which demonstrated a person centred approach further development was still needed in the overall quality and content of care records. They lacked information to demonstrate people had ownership and involvement in a format they understood and met their needs. There were missed opportunities to demonstrate that people's views were being sought, heard and acted upon. In addition further development was needed to ensure staff were provided with clear guidance, based on current best practice. This included information on providing the right support to people where their anxieties placed them and/or others at risk. Holistic needs where also not adequately planned for in order to demonstrate how staff were ensuring all had access to a fulfilling and purposeful everyday life.

At the February 2017 staff meeting, management informed staff about their aims to ensure that the personalised care plans, so a person could be 'cared for by a new member of staff exactly in the way they wanted to be cared for'. They said this was especially important taking into account there had been several changes in staff, and as some people would not be able to verbally communicate their needs. At this inspection we found that a lot of information was still missing from care records and staff were not routinely referring to them. A staff member told us they had, "Read a couple." They confirmed that they were, "Told all the most important information," during the staff handover between shifts. We also found staff had not always completed and / or updated people's care records. When we tried to clarify with a member of staff what medicines a person was taking and why, they told us the changes had been made following a review but nothing had been written in the relevant section in the care plan. There were other examples where records were out of date or information was contradictory. Examples of this included a person who had said they didn't want to be checked at night; however, it also showed that their continence pad was being checked during the night. Another person's records said they were allergic to milk, but records showed they drank normal milk. The interim manager said they were not aware of this allergy and they had not shown signs of being unwell.

A person's accident and emergency grab sheet and hospital passport for people with learning disabilities, both required updating to reflect current needs and be more informative. In the event of the person needing to go to hospital the correct information was not available. A visiting professional remarked that staff, "Write the ordinary, but not the extraordinary." This was our observation, because staff focused on recording the tasks carried out but not the quality of the person's day, their mood, ability or the impact of staff's encouragement. Where a person's care records provided information on their goals, aspirations and what they liked to do, they were more a statement. This is because there was no further information to set out how staff were supporting them to achieve them.

There was a reliance on verbal information, instead of keeping and referring to accurate records. We were concerned these practices were not sufficient for staff to understand a person's needs and how they could be supported, cared for consistently and safeguarded against inappropriate or unsafe care.

Feedback from relatives and care professionals also reflected that more work was needed to ensure people and those acting on their behalf, were able to actively contribute to the planning of their care, and where applicable, kept updated on any changes that could impact on the person's health and welfare.

There were no systems in place to regularly involve relatives and/or advocates in people's reviews, unless triggered by the commissioner funding the service. This could be yearly or longer. One relative said the person they visited, "Haven't had a review for a couple of years." However they were not worried, as they were regular visitors which enabled staff to keep them updated.

Where relatives had historically formed good relationships with staff, they felt that they were being kept up to date and praised the quality of the care being provided. One told us that the management regularly contacted them and kept them updated. Feedback from other relatives where the relationship had not been so good, felt that it had recently started to improve. One remarked they were always told, "After the event," about any health issues, but now they were being kept updated. Another relative told us it had, "Got a lot better in the last few months," and was pleased when the new manager had contacted them to arrange a date to visit and look through the care plan to discuss the person's support needs.

Support for people to follow their interests and take part in social activities was inconsistent. Where this was happening, one relative praised the work of the activities coordinator, "Brilliant, got lovely ideas... really got them doing things." Another spoke about the impact the person's new mentor (one to one support worker) had through supporting them in carrying out garden and maintenance tasks, and the fulfilment it brought. They said that the person, "Has got a quality of life now." Another person pointed out the vegetable plot and how they also helped out and what they were growing, which they would then eat.

However, feedback from relatives and through the CQC 'share your views' webpage, care records, and observation, identified where other people were at risk of social isolation and boredom. One relative described staff not engaging with people which resulted in them, "Just sitting around," and it felt more like, "God's waiting room." Another relative said they felt that there was, "Not a lot going on," which resulted in them spending a lot of time "Just sitting", and worried about the person becoming institutionalised, and staff needed the skills to turn this around.

This was an on-going breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaint procedure in place, and the contact details of how to contact visiting senior management and the provider was also displayed. Where a relative told us they had raised a concern, they said that the interim manager had dealt with it in an effective manner. We saw people approaching the office throughout our inspection, asking questions, and having their concerns resolved. This demonstrated that people knew who to come and speak to if they had a concern and felt comfortable to do this. Concerns were raised with us directly about the lack of visibility and proactive communication from the provider about changes in the service. When we met with the provider's representatives after the inspection they told us they would look into the reasons why people felt this way and explore how they could improve this.

Inadequate

Is the service well-led?

Our findings

Our last inspection of 18 March 2016 found a breach of Regulation 17 (Good governance) this was because we found the processes to monitor the quality of the service, were not effective enough to identify and address areas that needed improvement.

The provider wrote to us and told us about the improvements they had made. This included putting 'measures in place to ensure that the quality of our service is maintained at a higher standard'. To ensure the improvements were sustained, weekly visits and 'unannounced inspections' would be undertaken by members of the provider's management team. The leadership told us that they welcomed a return inspection, as they had confidence that the breaches had been addressed.

During this inspection we found that the provider was still unable to demonstrate that they had effective oversight of the service. This put people at risk where it impacted on the safety and quality of service people were receiving. We found the quality assurance checks in place to monitor the management and quality of the service were not robust enough. For example, verbal / written information had been taken at face value and not checked to ensure that improvements were being consistently imbedded and all people were benefiting from changes. This led to a two tiered culture within the service which people, staff, relatives and professionals all commented on, with some having a very positive experience whilst others had a very poor one.

Shortfalls identified during the inspection around safe recruitment, induction, training, fire safety, health and safety showed that policies and procedures were not being followed and this had not independently picked up through effective oversight and governance.

Records showed that a member of the provider's management team met regularly with the manager, providing a forum to give support and gain an oversight of what happening in the service. The records did not always provide a clear audit trail to ensure any agreed actions / decisions were being acted on and completed. For example where the provider told us funding had been agreed to repair / service / replace items as part of maintaining a safe, well maintained environment for people in March 2017, this had not been followed through. Where the manager had identified specialist training was required in April 2017 to support individual person's needs, there was no further information / agreement to demonstrate what was happening. This had led to delays in effective action being taken which did not support the staff to provide the care required.

The quality monitoring checks had not picked up potential hazards which could impact on people's safety. For example where people's bedrooms had no number / name / signage to identify if it was occupied, and with several empty rooms, this could hinder emergency services, and safe evacuation. Unoccupied bedrooms were not locked, we saw a person attending day care, had put themselves to bed in one (unbeknown to staff). When we asked two staff the location of the service's evacuation plan they were unable to answer. When we asked the interim manager they were unable to show us an overall plan of the people who were occupying rooms, the amount of staff and mobility aids required to support evacuation or

whether this was in fact appropriate. We were concerned about this as at night with two night staff; this needed to be taken into consideration.

The provider showed us the local Commissioner's report following a review of the service carried out in December 2016. This took place when the provider's action plan told us that they had taken effective action to meet comply with the breaches of regulation at our last inspection. The Commissioners report was positive about progress but also reflected some of the same shortfalls we had identified around fire awareness training and requiring more detail in people's personal emergency evacuation plans (PEEPS). This showed that we could not wholly rely on the information provided in the action plan. Further the findings of this inspection show that any improvements were short lived and not sustained.

Relatives told us that the leadership of the service did not promote an open culture. They felt that they were not being kept updated on significant events, such as the changes in management, and how this could affect people's and staff anxieties. They spoke about the lack of communication. One relative told us they were, "Very unhappy with Eleanor as an organisation, not once have they contacted us since they have taken over." Another told us they felt the situation was, "Pretty confusing," as they didn't know what was happening. Four people's relatives mentioned that there were, "No relatives meetings." One relative said that there used to be a newsletter organised by a support worker, which they found useful, but wasn't continued when the staff member left.

The lack of effective communication with staff had resulted in the passing of inaccurate information through rumours, which had the potential to cause distress. During this inspection we picked up on staff's anxieties about changing leadership, future of the service and introduction of new ways of working. Several relatives were not aware of the findings of the last CQC report. We saw that the provider's website provided this information. However, the visiting leadership had not picked up that the service was not displaying their rating, and the report had not been made available in the service. When we alerted the interim manager that we could not see the report or rating displayed, this was addressed straight away.

We found improvements were needed in promoting an open culture as part of driving continuous improvement. The leadership spoke about the different forums they had to enable people, relatives and staff to voice their views and raise any concerns. This included resident and staff meetings, supervision, annual quality surveys, commissioner's reviews and visits from the provider's senior management. However this inspection shows that the outcome of these actions did not always identify an accurate picture of the service. Relatives and staff expressed some concern about personal relationships between some staff, which left them feeling uncomfortable to say what they really thought. There was no risk assessment to show this had been taken into account as part of the service's safeguarding/ whistle blowing policy. Therefore some relatives, staff and people using the service did not have confidence there would be no conflict should they raise concerns.

Another relative felt that the leadership could be better at inspiring staff to provide a quality service as they felt staff were too frightened to speak up. They said that staff were not being given enough praise for all their hard work from the leadership, "Quicker to criticise then praise …Too much stick," and not enough, "Carrot," to encourage staff.

When we met with the provider we discussed ideas about what they considered the root cause of these issues to be. They were clear that they had not understood the extent of the variances in the provision of care or the poor, out of date and on occasion institutional practices. They felt that new leadership through the appointment of an interim manager and support for the staff team could address the concerns. They were dismayed by the findings of our inspection and committed had started to make changes. Discussions

with two of the interim managers showed that action they were taken to get a good 24 hour overview of the service in supporting them where changes needed to be made. This included a mixture of staying in the service, doing unannounced visits, and attending staff handovers.

The service was not reflective of its description on their website, promotional material, mission statement and customer charter in providing specialist person centred care. They were not able to demonstrate that they were up to date in best practice and able to effectively promote the provision of safe, high quality care.

This is a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving personalised care and support to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk because they were not provided with safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not being effectively monitored to ensure they had enough to eat and drink and their nutritional intake supported their health and welfare needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes are not robust, established and operated effectively to ensure risks to people are mitigated and to provide a good quality service to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	People's needs were not being met due to insufficient staffing levels.