Care Quality Commission

Christchurch Court Limited

Christchurch Court - 4 Christchurch Road

Inspection report

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13 July 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on the 12 and 13 July 2016. This service provides accommodation and personal care for up to 17 people who require neurological rehabilitation resulting from injury, illness or disease. At the time of our inspection there were 15 people living at the home.

The service did not have a registered manager in post. At the time of our inspection a manager had been appointed and was due to take up the post shortly. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social care Act 2008 and associated regulations about how the service is run.

There were not sufficient numbers of staff deployed to safely meet the needs of people who used the service. People were not always treated with dignity and respect as they were left waiting for personal care and support.

Care plans and risk assessments were in place which gave staff detailed instructions as to how to support people and mitigate any identified risks. However, the staff did not always have the time to read the plans so were not always aware of people's needs.

Care staff did not receive appropriate supervision to enable them to fulfil their responsibilities. This meant that people were not always protected against the risk of avoidable harm as staff were not aware of their responsibilities with regards to safeguarding people who lived at the home.

People were able to provide feedback, however this was not always acted on. When staff had identified that some of the accommodation was not always suitable to meet the needs of people no action had been taken and the provider was slow to respond to information about broken equipment.

The provider had not ensured that there were clear lines of responsibility and accountability at all levels. Leadership was poor and staff were not fully aware of what was expected of them. The lack of leadership on a day to day basis had significantly impacted on the quality of care that people had received. Staff morale was very low, staff felt devalued and unsupported.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Assessments of people's needs and associated care plans had been reviewed regularly. People received planned person centred therapeutic interventions in line with their assessed needs.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The

action we have taken can be seen at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding incidents were not being recognised and reported to the relevant authorities or to the management team.

There were not enough staff deployed to meet people's needs and keep them safe.

There were not enough adequately trained staff to administer medicine.

There were appropriate recruitment practices in place.

Is the service effective?

Requires Improvement

This service was not always effective.

Staff did not receive adequate support, supervision and direction to carry out their roles.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Peoples physical and mental health needs were kept under regular review. People were supported to access relevant health and social care professionals to ensure they receive the care, support and treatment that they needed.

Is the service caring?

Requires Improvement

This service was not always caring.

People were not always treated with dignity and respect and they were left waiting for care and support for unacceptable periods of time.

People were supported to access advocacy services if they

required it.

Friends and relatives were welcomed in to the home.

Is the service responsive?

Requires Improvement

This service was not always responsive.

The assessment and admission process in to the home was rushed and at times chaotic and required improving.

Staff were not always person centred in their approach and some care practices had become task focussed.

There were inconsistencies in how people's concerns and complaints were dealt with.

Assessments of people's needs and associated care plans had been reviewed regularly.

Is the service well-led?

Requires Improvement

This service was not always well-led.

There had not been a registered manager in post for six months. A new manager had been appointed and was about to commence working in the home shortly.

There was a lack of consistent day to day leadership and managerial oversight of the care and support provided to people.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We inspected the service on 12 and 13 July 2016. The inspection was unannounced. This inspection was completed in response to concerns in relation to a lack of staffing, particularly at night, and concerns with how people's medicines were handled. We also received concerns that new people were being accepted into the service that the staff could not meet their needs and concerns that people were not receiving the support and rehabilitation they required.

This inspection was completed by one inspector. Before the inspection we reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During our inspection we spoke with four people, two relatives, nine members of care staff, a temporary deputy homes manager, a senior (Grade D) member of staff, two catering staff, a visiting manager and two representatives of the provider.

We looked at care plan documentation relating to five people and medication administration documentation. We also looked at other information related to the running and quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas and arrangements for managing complaints.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information raising concerns about the staffing arrangements in the home and about the ability of the care staff team to meet people's care and support needs in a safe and consistent way. These concerns were primarily related to the staffing arrangements in place to provide for people's personal care needs.

During our inspection we saw that the provider used a variety of tools to assess the dependency of people living in the home and to establish the level of staff required to support their needs. The provider told us that although there were some vacancies in the home that the staffing levels maintained were based on full occupancy of the home. In addition to the care and managerial staff available a team of therapists and specialist staff worked with people to support their specific rehabilitation pathway.

People living in the home felt that there was sufficient therapy staff available and told us that they were happy with this aspect of the staffing arrangements in place. However we saw that the deployment of care staff was impacting on people's experience of personal care; with people having to wait significant periods of time to have their personal care needs met. One staff member said "We just can't get to everyone at the right time and people have to wait a long time; it breaks my heart that they have to wait sometimes for over an hour." We observed that one person who required staff support to attend to their personal hygiene in the afternoon did not receive this support for nearly an hour; this person was becoming increasingly anxious and upset as they were expecting their relatives to visit and wanted to be ready for them. Another person used their call bell at 9.20am and requested support to attend to their personal hygiene and get dressed; it was 10.30am before care staff could attend to their needs. Care staff told us that they simply did not have the time to attend to these individuals when they had requested. One person living in the home told us that they knew they could only ask to go to the toilet at certain times as there was not enough staff on duty to help them at other times.

At the time of our inspection two people continually required care staff on a one to one basis throughout the day and another five people required two staff members to safely attend to their personal care and moving and handling needs. The staffing levels did not allow staff to provide this level of care whilst at the same time ensure that other people in the home were supported with their care or planned activities. On the day of our inspection, there were eight staff on duty, however in addition to the people receiving one to one support; one person was being supported out of the building to attend a planned activity; another two staff were out of the building supporting people to health appointments.

Throughout the two days of our inspection we spoke to nine staff across both teams and they all without exception told us that there was not enough care staff to safely meet the current needs of the people living in the home. They expressed their concerns that staffing was so stretched at times that this was placing people at risk. For example they told us that they were leaving people, who were at risk of choking, unattended when they were eating and drinking. They said that they had to do this as they were required to respond to other situations. Care staff told us that this was a regular occurrence and although they recognised the serious risks involved they said that they continually had to make these judgment calls

knowing that someone would be left at risk as a consequence.

The acting manager and the Interim Operations Manager confirmed and records evidenced that at times staffing levels were at only 60% of the level identified by the provider as being necessary; there had also been a recent increase in the use of agency staff. We saw occasions where over half of the staff on duty were agency staff. Care staff told us that they felt it was an 'almost impossible' situation when there were so many agency staff on duty as they did not know the complex needs of the people living at the home and were therefore unable to carry out care independently which was resulting in delays of people getting their care needs met.

The way in which staff were deployed meant that at times there was insufficient numbers of staff on duty who were competent in administering medicines. This resulted in some individual staff working 14 hour shifts to cover all planned medicine administration times; they told us that they were spending up to 10 hours of their shift actually administering medicine. These staff said that they were ending their shifts extremely fatigued; concerned that they had administered medicines incorrectly and told us "clearly this cannot continue; I am so afraid of there being a major medication error, but what choice do I have?" We were particularly concerned to also find that there were no staff deployed on the night shifts who had received training and who were deemed as competent in the administration of medicines. The provider told us that they had on call arrangements in place if anyone required medicines during the night and that these arrangements had been in place for a long time. However we consider that this arrangement exposed people living in the home to unacceptable delays in receiving any medicines they may require during these times. Particularly as staff told us, that they were aware, that at times people had been asked to wait for day staff to arrive, so that they could be given the as required medicines that they required, rather than using the on call staff.

Staff at all grades talked to us about their personal anxieties and frustration about not being able to care for people safely and in a timely way. One staff member said "We can't support people in the way that they always need; we are so busy people have to wait; and then another new resident comes in and we feel even more stretched; I have to make judgement calls on which people need my support and which people I think are the safest to leave for a period of time without support."

Care records did not contain any detail about the delays in the delivery of care described by staff; however with the information we received prior to the inspection and the consistency of the accounts given by care staff of various grades it is our judgement that staffing arrangements were not currently able to meet the needs of people living in the home and were in need of review.

This was a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by care staff who recognised and responded appropriately to their own concerns about neglect or omissions in people's care provision. Although care staff had received training on how to keep people safe from harm and were supported by up to date policies; they had failed to consistently escalate their concerns about poor care to the relevant authorities or to the provider; this meant that these matters were not appropriately investigated or addressed. Care staff told us how people's care was delayed for unacceptable periods of time, resulting in people not receiving the personal care that they needed and people laying in a urine soaked beds for up to 60 minutes on numerous occasions. They also told us that people who were assessed as at a high risk of choking were left when eating or drinking and that this practice was a regular occurrence because staff were required to respond to other situations.

Staff recognised that this was neglectful care; they said that they had tried to raise their concerns with senior management but that nothing changed. One care staff said "When I have said to a member of the senior management team that we are not able to meet peoples care needs in a timely manner I have just been told 'there is enough staff on shift'; I never feel listened to." Another staff member said "I want to be here for the residents and meet their needs, I know their care isn't delivered as quickly as it should be and I am always apologising to people for it; but it keeps happening and I can't see how it will change."

The provider told us that they were not aware of the examples of poor care that care staff shared with CQC during our inspection and we saw that these were not recorded in care records or incident reports. The provider told us that they regularly monitor data about safeguarding matters and about care outcomes and we saw that this data had not highlighted any increased concerns about outcomes for people living in the home. There were no records to show that staff had attempted to escalate their concerns to senior managers in the home.

However care staff told us that they had attempted to raise these matters with senior management on several occasions but felt that their concerns were not acted upon or listened to. One staff member said "I've stopped reporting my concerns, I know I should carry on [reporting concerns] but it's like hitting the proverbial wall; nothing changes."

Our records confirmed that staff had not escalated their concerns to Northamptonshire County Council safeguarding team or to the Commission so that these could be independently investigated and addressed.

This was a breach of Regulation 13(1) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were appropriate medicine management systems and processes in place the way in which staff were deployed meant that there was not always enough appropriately trained and competent staff available. We brought this to the attention of the provider and required that action be taken to address these matters. We found that staff did not always transcript peoples prescribed medication correctly onto their medication administration records and this had led to one person being given the wrong amount of medicine on more than one occasion.

Care staff told us that they were often distracted when administering medicines and this had on occasions led to errors particularly in the signing for medicines. One care staff said "We have a tabard that we wear to assist in stopping people from distracting us but if the call bells are ringing and no-one else is available then we need to answer them and attend to the person." Another staff member said "Sometimes when new people are admitted there isn't always the time to sit and write up medication record sheets (MAR) in an unhurried way; I have made the mistake of writing the wrong information on the MAR sheet and it was because we were rushed and not enough staff were on shift; I felt awful about the error."

When medication errors occurred care staff were initially suspended from medicine duties until they undertook re training and competency assessments. One record of an investigation stated the reason for the error was 'Due to the amount of pressure that medication staff are under, this will be brought up with the director'. At the time of our inspection we were told that this had not yet been discussed with any director.

This was a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was not always maintained to the provider's own standards. For example, there were non-

working lights in the main kitchen over the cooker and these had not been in operation for several months. The flooring in the main kitchen was split and had lifted and was identified as a hazard on an accident/incident report, however on the first day of the inspection the floor had not been repaired and was still a risk, but on the second day the floor had been taped down to ensure it was safer. The electric fly killer in the main kitchen had been out of operation for 6 weeks. The dishwasher was not working; kitchen staff told us that this has broken down on many occasions in the last six months and was a constant cause of frustration. Catering staff were concerned that at the times when the dishwasher was not working due to the thermostatic hot water controls in place there was not a supply of hot water in place to ensure that dishes were cleaned to a standard required to control infections. Staff told us there was a system in place for reporting maintenance issues; however they lacked confidence in the system due to the amount of time it took to address concerns and for repairs or maintenance to be achieved.

People were assessed for their potential risks such as falls. People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. For example where people's mobility had increased their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how they were to mitigate people's risks to ensure people's continued safety. For example, where people were identified as being at risk of pressure ulcers, the risk assessments and care plans were updated to reflect that staff carried out more frequent position changes to relieve people's pressure areas.

There were appropriate recruitment practices in place. Staff employment histories were taken into account and staff backgrounds were checked with the Disclosure and Barring Service (DBS) for criminal convictions before they were able to start work and provide care to people. This meant that people were safeguarded against the risk of being cared for by unsuitable staff. All staff confirmed that they were unable to begin working until they had received satisfactory references and background checks.

Requires Improvement

Is the service effective?

Our findings

Although we were told that therapy staff received the professional supervision and support they needed, we found that care staff who did not receive guidance, support and formal supervision they required to enable them to carry out their roles. Care staff told us and records confirmed that they hadn't received supervision in a long time; one member of staff told us they had only received one supervision in a year. There had not been a registered manager in post for six months and this had impacted on the opportunity for care staff to receive formal or informal supervision. Senior care staff told us they were aware that they should be supervising staff and completing competency assessments of their care practice but said they didn't have the time. One care staff member said "I know what we should be doing but we never get the time to sit down with staff and offer supervision; any spare time that we do have is spent supporting the people who live here; I know I haven't supervised my staff for quite a while."

We found that the lack of day to day leadership, support and staff supervision was directly impacting on the quality, consistency and safety of some aspects of the care and support being provided to people living in the home. Care staff were making independent decisions about risk management in the home and were not receiving the guidance and support they needed to ensure that care and support provided was safe and appropriate. We observed care staff supervising, caring and supporting people without interacting with them on a personal level and that their approach to care was task orientated. The provider's representatives had also observed staff failing to interact on a personal level with people for example reading newspapers or magazines when they should have been engaging with people. The lack of supervision had meant that this practice had gone unchallenged and was becoming embedded in some care staffs practice.

This was a breach of Regulation 18 (2a) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff received a thorough induction which included classroom based learning and shadowing experienced members of the staff team. The induction was comprehensive and was delivered in part by the multi-disciplinary team and included key topics on rehabilitation and introduction to acquired brain injury and neurological conditions. Staff told us and records confirmed that there had been a recent dip in the level of staff training completed, however we were informed that this was now a key priority for the deputy manager who was about to return from a period of extended leave.

Where staff had received training they did not effectively apply the knowledge and skills gained when carrying out their roles and responsibilities. Staff confirmed and records showed that staff had received training on safeguarding people from abuse. However, it was clear that some staff did not report or respond appropriately where they had concerns and the quality or safety of peoples care.

People told us that staff always asked for their consent before providing any support and that they respected their personal needs and preferences. Relatives also said they had observed that staff sought consent before providing care. Staff provided examples of how they always sought consent before providing any personal care or support and this was confirmed during our observations. Individual plans of care also

contained information about people's consent to care and treatment and details about their lasting power of attorney for a time when people may not have the mental capacity to make decisions themselves.

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).

The deputy home manager and the staff team were knowledgeable and experienced in the requirements of the MCA and DoLS. Detailed assessments had been conducted to determine people's ability to make specific decisions and where appropriate DoLS authorisations had been obtained from the local authority. Senior staff had training in the MCA and DoLS and had a good understanding of service users' rights regarding choice; they carefully considered whether people had the capacity to make specific decisions in their daily lives and where they were unable, decisions were made in their best interests.

Catering staff ensured people were provided with meals that met their nutritional and cultural needs. We saw that they prepared meals to suit each person's individual needs, such as pureed food; they had access to information about people's dietary needs, their likes and dislikes. One person told us "The food is lovely, definitely no complaints from me." Another person said "When I leave here to go home I shall want to come back for the meals; that's how tasty they are."

Staff were aware of the people who needed assistance and who needed prompting to eat; most people chose to eat together in the dining room which was set out so people could eat sociably. People were offered alternatives to the planned menu when they were given the menu choices in the morning. One member of catering staff said "We get to know what people like and we have a list of people's favourite food and any allergies." Records showed that people were encouraged to eat and drink regularly.

Staff assessed people's risk of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietician for further guidance when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely, for example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed or thickened their drinks to help prevent choking. However, there were times when people were not supported with eating and drinking when they had been identified as at risk of choking. Where it was necessary, staff monitored the amount that people drank to ensure that they stayed hydrated. Appropriate equipment has been purchased to support people nutritional intake and dignity. For example the 'Neater Eater' which provides support to people who have tremors while eating, this piece of equipment enables people to be independent while eating and helps to maintain their dignity.

People were supported to access appropriate healthcare services including hospital appointments, their GP, podiatrist, optician, and the providers own team of consultants and therapists. Each person had a planned pathway of person centred rehabilitation which involved sessions with physiotherapists, occupational therapists and speech and language therapists. The provider had their own occupational therapy room on site and this was used on a daily basis. The team of specialists consisted of medicine consultants, neurologists and a range of therapists who assessed people continuously on the rehabilitation pathway and adapted people's therapy needs as people progressed.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect because there was not always enough skilled and trained staff deployed in the home to meet people's needs in a timely manner. Five care staff we spoke with told us on many occasions they had to leave people in soiled beds for periods of up to 45 minutes; they said that this was solely due to not having enough care staff to support people at the times they required. One staff member said "It goes against everything; I have to leave people until there is another member of staff free to help me; often it is 45 minutes or even longer; it shouldn't happen and I'm ashamed that I work somewhere it does happen." Another care staff member told us "What can we do; other staff are supporting other residents so we have no choice but to ask the person to wait. I feel all I do is apologise all of time to the residents for their delayed care."

People living in the home were not always supported to the toilet in a timely manner. One person told us "I know if I ring my bell to use the toilet between 7.30am and 10.30am the care staff just won't have time to take me; so I try and time it the best I can when I think they will be free." The same person also told us "I have my family visiting and I have called my bell and asked to get up and dressed; it is 2.30pm so I'm hoping they will have some time but I've already been waiting 20 minutes." We observed that it was 50 minutes before two staff were available to support this person.

Care staff told us they have to prioritise people depending on how insistent they were with their use of the call bell. One member of care staff said "We might be planning to support one person who needs two staff to support them but another person may have been persistently ringing their call bell so we will support them instead; because otherwise someone has to keep stopping what they are doing to answer the bell. I know it isn't ideal but that's the kind of decisions we have to make on a daily basis.

This was a breach of Regulation 10(1) Service users must be treated with dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported by care staff that had a caring approach. One person said "I know it's not the girls [care staff] fault I have to wait for my care; but when they do help me they are brilliant, really gentle and take their time with me." Another person said "I get anxious a lot of the time and staff will try their best to sit and talk with me and help me work things out; I can trust them which has not always been the case in previous places I've lived."

Permanent care staff demonstrated a good understanding of the people they had supported for some time and were able to tell us about people's preferences about how they liked their care to be delivered and the best way. However, for those people who hadn't lived in the service for long some care staff were unsure of their needs. One staff member said "We try to get to know people but just lately people have been admitted in a quick succession and you can't learn three new peoples care needs in one week."

People were involved in personalising their own bedrooms. For example, one person showed us their room and it had their own personal items around that they treasured and had meaning to them including

photographs and memorabilia from their lives. This person said "I love my room; it has a bathroom as well."

Staff understood the need to respect people's confidentiality; not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in people's care plan or were discussed at staff handovers which were conducted in private. Staff respected people's privacy and ensured that all personal care was supported discreetly and with the doors closed. We saw that staff supported people to maintain their dignity and offered support to people to adjust their clothing when this had been compromised.

In order to help people build caring relationships with each other, each person had an identified key worker, a named member of staff. They were responsible for ensuring people had access to resources and support they required and we saw that people had good relationships not just with their keyworker but with all members of staff. One person said, "I get on well with all the staff here, but there is one that I get on very well with and I feel like I can tell them everything. That's my keyworker; you would never get a better one."

People were supported to access advocacy services when they required independent support. Staff understood when people may need the support of an advocate, for example if somebody had little or no support outside of the home. One member of staff told us, "We have used advocacy services for lots of people, we have referral forms and we support people to complete them if they require an advocate. Advocates also attend our residents meetings on regular basis." We saw that people also had financial appointee's and the required documentation was in place.
Visitors, such as relatives and people's friends, were encouraged at the home and made to feel welcome. One relative said, "I visit every day; I am always made to feel welcome. There are always lots of new faces though which I think are agency staff so I don't ask them about [my relative's] care because they haven't supported them. Staff are often run off their feet though and dash around; there is always someone waiting for something." We saw that staff recognized people's visitors and greeted them in the home. Staff used their knowledge about people's visitors to engage people in meaningful conversations and visitors were supported to use areas within the home to spend time with their relative or friend.

Requires Improvement

Is the service responsive?

Our findings

Prior to our inspection we received concerns about the adequacy of the assessment processes prior to a person arriving in the home and about the adequacy of the information shared with care staff about the new person's needs and how these were to be met.

We found that when referrals to the service were received the multi-disciplinary team (MDT) which consisted of consultants and therapists met with the person and carried out extensive assessments to ascertain whether the service could meet their needs. From the assessment the MDT would create a rehabilitation care pathway and detail the kind of interventions a person would require, for example, physiotherapy. We saw that there were clear documentation of this process within people's files. However we were told by care staff that recently they had only been given a couple of days' notice of a new person coming to the service and that they did not have time to read about peoples assessed needs or to develop initial care plans before they came in. Care staff felt that this placed them under great pressure as they did not understand the person's needs and were particularly concerned where the person's needs were complex and where communication was an issue.

The providers own process for new admissions details that the MDT support people in the first 24 hours of admission in to the home to enable a smooth transition and to undertake assessments such as moving and handling. The provider told us that the practice was not consistently happening and recognised that this had impacted on the information and support available to care staff in the early days of a person's stay. The provider confirmed that they would quickly reinstate this practice as a priority.

Staff told us that one person who moved in to the service was inappropriately placed in a bedroom where the call bell could not be reached from the bed; the person was unable to get out of bed independently. Staff had not approached the management team to arrange for another room or for other equipment to be made available saying that they did not feel listened to by senior management and that they had stopped reporting their concerns about a lot of issues. One member of staff said "If this person required support the only way staff knew was if they happened to be in the corridor when they called out."

Staff were observed working in a task orientated manner rather than a person centred way; their resources were stretched and people's care became 'tasks' due to the time limitations. People did not always have their needs responded to in the way they preferred or in a way which considered their individual needs or preferences. We observed one person was outside the staff office and asked the same question to three different members of staff, we observed two staff acknowledge the person and responded that when they had time they would complete a specific task for them; a third member of staff didn't give the person an opportunity to ask the question and instantly responded they didn't have time right now as they were doing something else. This person told us "someone will sort me out soon."

Care plans were detailed about the risks people faced in relation to their physical and emotional circumstances; however care staff told us they did not always have the time to read these. Each person's care plan was focussed on them and their individual circumstances and needs. Staff reviewed people's care

plans regularly and adapted them to meet people's current needs. The service used recognised clinical outcome measures to monitor people's progress on the rehabilitation pathway. Some people who were receiving short term rehabilitation had many updates and changes in the care plan which evidenced how the person had progressed with the levels or therapy they were receiving. Other people who had lived at the home for a longer period of time had regular reviews of their care in which they felt fully involved with. One person said "I have my review next week, my [relatives] are coming as well and we will be talking about the next steps for me in my goal of living more independently."

Staff were responsive to people's call bells, we observed that it was a priority for staff to attend to people and see what support they required, however people and staff informed us that they were often unable to support people at that time and people were asked to wait for care and support. One person said, "The staff always answer my call bell quickly, if it is something quick they can help me with then they do it, but if it is help with my personal care I know I will have to wait; but they are very apologetic about it."

People were involved in activities either through planned therapeutic programmes or personal choice. We saw that some people were able to go out independently and chose to visit friends or go shopping in the town centre. One person told us "I go and visit my friend often who lives nearby, it is really important to me that I can do that." Other people chose to use their computer to play games or search the internet. Some people were supported to attend a day centre where they socialised with friends and learnt new skills. People told us about visits to local pubs, café's and The Rock Club, this club has been set up by four providers and provides activities for people with acquired brain injuries. Activities were also based on rehabilitation, for example; Planning, shopping and cooking a meal and managing finances.

There were inconsistencies in how people's concerns and complaints were dealt with. People living in the home said that they were aware that they could raise a complaint however stated that they didn't think anything would be done. Care staff told us that two people had verbally complained about another resident who was keeping them awake at night. We spoke to one of these people who said "Nothing has been done from my verbal complaint so I have made a written one now; that was three days ago and it hasn't been acknowledged yet." The same person went on to say "I know people have different needs but being kept awake at night is slowing down my rehabilitation because I am too tired in the days to do my exercises." We spoke with the senior management team and they were not aware of the complaint but told us that someone would be dealing with it. Other complaints that had been raised in the past six months had been appropriately investigated.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager for six months. There was a temporary deputy homes manager in place and another senior member of staff who oversaw the day to day operations. A registered manager from another service had been supporting the service for a short while and there was an interim operations director and a group governance manager who also supported the service. A new manager had been appointed and was about to commence working in the home shortly.

The provider had a governance structure in place, board meetings and meetings with the directors took place on a regular basis. The provider monitored on a monthly basis many quality assurance area's including medication errors, hospital admissions, notifiable events, complaints and other audits that were undertaken in each service and these were discussed at each board meeting. However despite these systems and processes the provider was not aware of staff's perspective of the safety and quality of the care and support provided.

The provider made a number of managerial changes to support the home and to oversee the safety and quality of care when the registered manager left in February 2016. However at the time of this inspection we found that care staff were not receiving the day to day support and leadership they needed and this was having an impact on the safety and quality of care and support people received. It was apparent that communication pathways had broken down and were unable to support the consistent two way cascade of information between the directors of the company and care staff.

The provider informed us that care staff had not raised any concerns with them in relation to inadequate staffing levels, how people were put at risk and how they felt about their role within the organisation. Care staff told us that they had lost all confidence in the management of the service to listen and respond to their concerns about the safety and quality of care being provided. They consistently told us that they had escalated concerns yet nothing had been done and they felt totally devalued and demoralized. This led to staff making independent decisions about care priorities in the home and they were not always seeking the support, guidance or assistance from senior management. One staff member said they felt "isolated, unimportant and undervalued", another staff member said "I've never dreaded coming to work this much before; I don't go home feeling I have helped someone have a good day; I go home feeling like people have had a dis-service."

Care staff told us that they were often unable to take their rest break which had resulted in some care staff working up to 14 hour days without a break; we were informed this was a regular occurrence. One member of staff gave an example; the only chance they had to take a break was to swap roles with another staff who was sitting with a person on a one to one basis and eat your lunch while providing the one to one observational care. In addition we found that care staff were not always receiving the supervision, direction or structure that they required to provide good care and many of the staff told us they were unhappy and discontent with the way in which the home was being managed. Although they felt supported by their colleagues they were consistent in their view that the senior management of the service was not listening or taking their concerns seriously.

The provider had systems in place to monitor the quality of the service, however it had not been identified through these audits that there not enough trained and competent staff who could administer medicine, that care staff were not receiving appropriate supervision and support; the MDT were not supporting people upon their admission to the home in a planned way in the first 24 hours as per the providers own process, planned admissions in to the service were rushed and care staff did not have access to care plans and risk assessments in a timely manner.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicine audits that were in place were very thorough and were completed on a weekly basis. The staff member responsible for this said "We have had some medication errors recently so to make sure we are on top of it we are monitoring it really closely we have put extra checks in place and I think it is working well."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Care staff did not receive guidance, support and formal supervision they required to enable them to carry out their roles.