Modus Care (Plymouth) Limited

Kanner Project

Inspection report

Colesdown Hill
Plymouth
Devon
PL9 8AA

Tel: 01752482670
Website: www.moduscare.com

Date of inspection visit:
26 February 2018
27 February 2018

Date of publication:
19 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 26 and 27 February 2018 and was unannounced. The previous comprehensive inspection took place on 10 October 2015 and the service was rated as Good. In April 2017, Modus Care (Plymouth) Ltd was bought by Salutem, however the provider remained the same.

Kanner Project provides care and accommodation for up to five people with learning disabilities who at times might display behaviour that others could be perceive as challenging. On the day of our visit four people were living in the service and each had their own self-contained living accommodation within the home. Modus Care (Plymouth) Limited owns Kanner Project and has three other services in Devon.

Kanner Project is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

In relation to Registering the Right Support we found this service was working towards doing all the right things, ensuring choice where possible and maximum control. Registering the Right Support (RRS) sets out CQC's policy registration, variations to registration and inspecting services supporting people with a learning disability and/or autism. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The registered manager had left in July 2017 and was in the process of being de registered with the Commission. 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. Recruitment processes were underway for a new registered manager. Following the inspection we were informed by the regional manager that an appointment had been made and the new manager would start in April 2018. In the interim, there was an "acting" manager who was receiving support from another registered manager, the regional manager and the provider's senior management team.

The provider's governance systems at Kanner Project required improvement to assess, monitor and improve the quality and safety of the people living at Kanner Project and the staff supporting people. The provider was aware of the areas where improvement was required, however, people and staff remained at continued risk due to poor provider oversight at the time of the inspection.

The acting manager and regional manager promoted the ethos of honesty and admitted there were improvements to make. An action plan was sent to the Commission following inspection feedback.

Most people at the service were had very limited verbal communication skills. However, those able confirmed staff were caring and kind. We observed people looked happy and where able, engaged with staff. Professional feedback was positive about the staffs caring attitude. Staff demonstrated kindness and compassion for people through their conversations and interactions we observed. However, we saw

people's dignity was not always promoted. For example the language used was at times institutionalised, staff did not always knock on people's doors and a greater awareness of the communal areas being people's living space was required. People, where possible, and those who mattered to them, were not always actively involved in making choices and decisions about their care and treatment.

Staff understood what action to take if they were concerned someone was being abused or mistreated. Relatives confirmed they felt their loved ones were safe. However, there had been a number of incidents at the service over the past 11 months. We found these were not always analysed for themes, patterns and opportunities for learning. For example there were 28 incidents in February 2018 but there was no further analysis of the type of incident and any changes or improvements which could be made to reduce these. Although action had been taken to address previous safeguarding concerns this had been reactive and not proactive.

People's care records were comprehensive but not shared with them in a format they were able to understand. Where people had a great deal of information about their care and treatment, care records were hard to navigate within the IT system the provider used. Reviews occurred with external professionals and people's funding authorities but regular 'in-house' reviews of people's care, goals and outcomes were not in place at the time of the inspection.

People and their relatives were encouraged to be part of the care planning process and to attend or contribute to discussions about care where possible. However, these discussions were not always well recorded or reflected in people's care records. Some support plans were out of date so did not reflect people's current needs. We also found end of life care plans required developing to reflect people's needs at this time in their life.

Staff morale was mixed. Staff supervision and staff meetings had re commenced to address this. Staff were keen to develop the service and give people the best care.

Risks associated with people's care and living environment were effectively managed to ensure people's independence was promoted where possible. There was planned building work being undertaken and external contractors were mindful of their presence within the service. The service required refurbishment and plans were in place to improve communal areas such as the lounge, kitchen and staff areas. Plans were also afoot to address the heating within the service with quotes for this work being undertaken at the time of the inspection. These positive changes to the environment would support people and staff to feel valued and the service to have a more welcoming atmosphere.

People were asked for their consent to care and treatment where possible. Staff knew people's individual communication styles well and had worked alongside speech and language professionals to develop skills in understanding and communicating with people. Some staff had attended training in sign language. Staff used their knowledge of people to assess their mood and needs by observing their body language, facial expressions and sounds which might indicate if they were content or anxious.

People were supported by consistent staff to help meet their needs in the way they preferred. However, it was not always clear if people were given a choice of male or female staff when they required support with personal care. Staff however told us where people had a preference this was known and respected.

The manager and provider wanted to ensure the right staff were employed, so recruitment practices were safe and ensured that checks had been undertaken.

People received care from staff who had undertaken the provider's essential training programme, but training to meet people's specific, complex health needs or behaviours was not in place at the time of the inspection.

People's human rights were protected because the acting manager and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.

People's nutritional needs were met because staff followed people's support plans to make sure people were eating and drinking enough and potential risks were known. However, there was a lack of choice available and staff shared concerns the budget was not sufficient. People were supported to access health care professionals to maintain their health and wellbeing.

Policies and procedures across the service were being developed to ensure information was given to people in accessible formats when required. However, at the time of the inspection these were not evident. Staff adapted their communication methods dependent upon people's needs, for example using simple questions and information for people with cognitive difficulties and we were told information about the service would be available in alternative formats if requested.

People and relatives felt comfortable raising any concerns and felt confident these would be addressed promptly but there was not an easy read complaint process visible during the inspection.

We found the communal areas of the home were clean. Where possible people were encouraged to participate in laundry and household cleaning. This supported development of their daily living skills and a sense of value and contribution to the running of the service.

People's medicines were well managed. People were given their medicines in their best interests following discussions with professionals and family who knew them well. We spoke with the acting manager about minor improvements which could be made to improve safety and these were promptly acted upon.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe.

People and staff were not always kept safe by the system in place to analyse incidents. People did not always benefit from a service that learned lessons from mistakes quickly to enhance their safety.

People's risks were known and monitored but the service did not always respond in a timely way when changes to risk occurred.

People were kept safe by sufficient numbers of staff although enhanced training in some areas would further improve their safety.

People were protected from harm.

People lived in a clean environment.

People received their medicine safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's quality of life could be improved. People's goals were not always clear so outcomes hard to measure.

People's human rights were respected and the service enabled people to have as much control over decision making as possible.

People were supported to eat and drink enough but more choice, healthier food options and involvement in food planning would improve their health.

People were supported by staff who were trained in the provider's essential topics but further training was required to meet people's specific needs.

People were living in an environment which was undergoing refurbishment.

People benefitted from access to external healthcare professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who knew them well.

People and their relatives would benefit from more involvement in care planning and decision making to help express their views.

People who were non-verbal were communicated with by staff who knew what their body language, facial expressions and hand gestures meant.

People's privacy and dignity were mostly met but improvements to the language staff used were required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and staff would benefit from more robust admission processes.

People had comprehensive care plans and risk assessments but these were sometimes hard to follow. People would benefit from care being further personalised to meet their unique needs, aims and goals. People's care plans were not available to them in a format they could understand, nor were regular reviews of their care occurring with them and their families.

People were not given a copy of the complaints policy in a format they could understand.

People did not have end of life care plans in place.

People's communication styles were known by staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

People did not live in a service which was delivering a high quality service. The governance system at the home was not robust.

People had experienced a number of management changes in a short period of time.

People did not benefit from a service which was innovative although the service was striving to improve.

People and their relatives were not always involved in developing the service.

The service was improving the way they worked in partnership with external agencies and people were benefitting from this.

Kanner Project

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.

The inspection took place on February 26 and 27 2018, was unannounced on the first day and undertaken by one inspector and a specialist advisor. A specialist advisor was someone with extensive background in learning disabilities.

The inspection was partly prompted from concerns we had received from the local authority, relatives and visiting professionals. They included concerns about the environment, the temperature in parts of the service, the cleanliness of the service, the communication within the service and access to people's records. We looked at these concerns as part of the inspection.

Prior to the inspection we looked the information we held about the service such as notifications and previous reports. We spoke with the local authority and spoke to three professionals supporting people at the service. 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. At our last inspection of the service in October 2015 we did not identify any concerns with the care provided to people.

During the inspection we spoke with staff about all four people who lived at the service. We met all of the people who lived at Kanner Project. We spoke with the acting manager and another manager from one of the provider's other services who was supporting the inspection. We spoke with four other care staff. Three people living at the service had complex needs that limited their ability to communicate and tell us about their experience of being supported by the staff team. Therefore we observed how staff interacted and looked after people and we looked around the premises. Following the inspection we spoke with the nominated individual and the regional manager. We asked further questions, responses and information was supplied promptly and an action plan was sent to the Commission which described the improvements the provider planned to make. We shared this with the local authority with the provider's permission.

We looked at records relating to two people's care and documentation related to the running of the home. These included care and support plans and records relating to medication administration. We also looked at quality monitoring of the service, staff recruitment and training files and read the provider's newsletter. We spoke with one relative during and after the inspection.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in October 2015 we found the service was safe. At this inspection in February 2018 we found the service was not always safe. The provider had already started to address many of the concerns we found, but further improvement was required, particularly the recording, analysis and learning from incidents.

Prior to this inspection we had received concerns from professionals, the local authority and relatives. These included concerns about the security within the service, the cleanliness of the service and the number of incidents which had occurred at the service in the previous 12 months. Concerns were also raised about the culture at the service.

People's accidents and incidents were recorded and these were analysed by the provider but only numerical data information was given to the service and not a record of themes to enable analysis. For example, the acting manager had information that 28 incidents had occurred in February 2018 but no further information was available. This analysis would support the service to consider themes, and whether action was needed to be taken to reduce the likelihood of reoccurrence. We found that in 2017 there had been a number of incidents involving one person who lived at the service. Although these incidents were mostly recorded by staff, there had been a lack of quick action taken to consider themes and learning to reduce the likelihood of further incidents occurring.

Staff told us this had been resolved in part by a change in the ownership of the company (new owners in April 2017) and in part by management changes (registered manager left in summer 2017). However, the situation for this person had escalated to the extent that the service was no longer able to care for this person safely and they had now moved from Kanner. Staff and the person concerned were placed at continuing risk of harm during this period, this had impacted significantly on the staff team. Some staff also shared their concerns that there was a lack of a shared understanding of what should be recorded as an incident. This could lead to under reporting of events.

The new owners of the company had recognised improvements were required and we were told positive behaviour support training was being rolled out and there would be a more person centred approach to people's incidents and support in place to improve safety. Staff debriefs were now also taking place to aid reflection and learning from incidents. Following inspection feedback the provider sent us an action plan advising one of their improvement goals, "To improve the analysis of incidents and events and what outcomes are required to change behaviour." Whilst these are positive steps, these are not yet embedded into practice.

All people living at the home had complex behaviours. Staff shared that the admission process had on one occasion been too fast due to circumstances beyond their control. This had resulted in a 'near miss' situation at the service. Action was taken following the event to reduce the likelihood of a reoccurrence. Staff had learned from this admission and precautions and checks were now in place to ensure security at the service was robust. Staff told us they wanted and required enhanced training to meet the needs of some

people at this service. This would support people's and staff safety. Following the inspection we received an action plan. This advised training had been requested on 21/02/2018 and that plans were in place to increase understanding and approaches which would benefit people.

Some people we met had behaviours which could place them at risk. During the inspection period the UK was experiencing adverse weather conditions. One person liked their door open (the door led into the garden) and liked to wear minimal clothing. Although staff were encouraging the person to wear clothing and closing the door whenever possible, there was not a robust care plan and risk assessment in place to ensure this person's safety during this extreme weather period. We spoke with the acting manager about this and requested a plan be put in place. This was actioned within 24 hours. Longer term plans the provider was taking included considering the heating system in this person's living area.

People, who had risks associated with their care, had them assessed, monitored and managed by staff to ensure their safety. Risk assessments were completed to make sure people were able to receive care and support with minimum risk to themselves and others. There was clear guidance in place for staff managing these risks, however, we found where there had been changes, risk assessments and care plans had not been updated. We also found although staff recorded conversations with people regularly, there was a lack of analysis of discussions to support further development of risk assessments. People had risk assessments in place regarding their behaviour, which could be challenging for others or the staff. Where required, staff liaised with external professionals to understand people's behaviours and minimise potential risks. A review of care plans and risk assessments was already underway by the management team at the time of the inspection to ensure information was accurate, relevant and up to date.

The lack of systems to analyse and learn from incidents, the lack of robust admission processes, lack of appropriate training and support for staff placed people and staff at risk of harm. Not reviewing and updating risk assessments promptly placed people and staff at potential risk.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the provider's safeguarding policy. To help minimise the risk of abuse to people, all staff had undertaken training in how to recognise and report abuse. Staff were aware of what they must report to the local authority to ensure people were protected and kept safe. There was a visible safeguarding flow chart in people's lounge. We spoke with the acting manager and staff about making this information more user friendly, in a format they might better understand and whether people would want this in their lounge.

Concerns from a relative prior to the inspection had included whether staff taunted, bullied and shouted at people. Whilst we did not observe or see any evidence of this during the inspection, we did recognise some staff required individual support and training to understand people's behaviours. This would have helped support them to understand a person's behaviours and not be influenced by their personal views. Staff told us they knew people well and for those people who were non-verbal, staff were observant for changes in mood, bruising and other changes which might indicate they were unhappy and at risk of harm. However these changes were not always recorded. We spoke with the acting manager about capturing this type of information to help alert them to potential abuse. .

Staff completed the Care Certificate and confirmed they covered equality and diversity and human rights training as part of their ongoing training. Conversations we had with most staff about people indicated a genuine regard for the people they cared for.

Recruitment processes ensured staff were safely recruited. This included checks carried out to make sure new staff were safe to work with vulnerable people. Staff confirmed they were unable to start work until satisfactory checks and references had been obtained. New staff records we reviewed contained information to confirm good recruitment processes were in place.

People had sufficient staff to support them. The acting manager told us there were new staff in post and the staffing team was more consistent, with little agency use. Relatives and other staff confirmed this. Most people had high levels of staff support to ensure their safety, the safety of others at the service and staff safety. Throughout the inspection we saw staff met people's needs, supported them and spent time socialising with them. However, some staff shared that newer staff lacked confidence with some people who lived at the home, particularly taking them out. This was managed by experienced staff that knew people well but required addressing in the event these staff were unavailable. We spoke with the acting manager about these concerns who advised protocols were in place when staff were supporting people in the community.

Due to people's complex needs and the interaction they were able to tolerate, some staff sat away from people. Where professionals had given advice to increase people's tolerance of staff, staff told us they were trying to do this but although interventions were recorded in daily records, it was difficult to easily see whether there was improvement over time due to the way this was recorded in the information recording system (an online care planning tool). We were told by the acting manager the care planning system used was one of the areas the new owners were looking to improve.

People received their medicines safely from staff that had completed training. Systems were in place to audit medicines practices and records were kept to show when medicines had been administered. People had been prescribed medicines on "as required" basis and there were instructions to show when these medicines should be offered to people. Records showed these medicines were not routinely given to people and only administered in accordance to instructions in place. We spoke to the acting manager about considering a system to reduce all medicine trained staff accessing the keys at any one time; this would mean in the events of an audit discrepancy the error would be easier to follow up. We also discussed with the acting manager using body map charts for creams so staff knew where to apply these on people's bodies. One person was on a medicine that required safer controls. These medicines were kept safe and regularly checked, but the recording of these medicines required improvement.

People lived in an environment which the provider had assessed to ensure it was safe and secure. Following an incident with a door being left open and one person leaving unnoticed, daily checks were now in place. Staff also confirmed checks were undertaken on the fire system and they were aware of evacuation procedures. A new maintenance person had been employed to work across the providers local services. This meant repairs and work were being undertaken more quickly than in the past. The service had a list of environmental improvements being planned. Health and safety checks within the service were not all in date (for example tests for Legionnaires), this had been recognised and action was being taken at the time of the inspection to ensure tests and servicing were completed and in date. Building work was being undertaken at the service and due for completion in March 2018. Contractors were aware of their presence within the service and working to ensure the least disruption and distress to people as possible.

People were cared for in a clean environment however there was a lack of a robust cleaning schedules for daily, weekly and seasonal cleaning duties based on best practice. Staff undertook the cleaning within the service and had received training in infection control. One person's linen basket was broken and another person's soiled linen was on their floor. These practices could increase the risk of cross infection. One staff member told us staff did not always use protective aprons when cleaning areas soiled with faeces. We did

not observe this.

We spoke with the acting manager about NICE guidance in relation to residential homes and discussed the need to balance the infection control best practice guidance with supporting people to manage their own laundry to enhance their daily living skills.

The acting manager and new provider were working hard to address areas of concern following feedback. The acting manager had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Staff we spoke with had whistleblowing information visible within the service. Some had used this process within the past 12 months to share concerns with the Commission.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in October 2015 this area had been rated as Good. At this inspection (February 2018) we found improvement was required to ensure people received effective care with clear goals and monitoring of outcomes, improved supervision processes, implementation of best practice guidance, training for staff in working with people with specific needs and better communication systems.

People were supported by staff who had received training in the provider's mandatory subjects, for example food hygiene, fire safety, medicine management, infection control, safeguarding adults and positive behaviour management. The new provider was also rolling out a programme of positive behaviour support (PBS). The intention was that there would be a PBS lead in each house and this would be a more personalised approach for people who lived at Kanner addressing their individual needs. Staff said they were provided with regular updated training and in subjects relevant to the people who lived at the home, for example Makaton training and training specific to the needs of some people for example training in obsessional disorders. Staff confirmed the Care Certificate covered Equality and Diversity and Human Rights training. However, the assessment process for people who wanted to move into the service had not always identified the skills staff needed in advance of admissions. Staff described how with one person they were 'learning on their feet' and through mistakes. Staff had learned through errors and put mechanisms in place now, but were worried they needed specialised training to help them understand how some people thought. An action plan following the inspection advised training had been requested.

The lack of training to meet people's complex needs and the lack of appropriate information on admission to help understand their needs, placed people at risk of receiving inappropriate care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed an induction which included a period of shadowing staff who knew people well. There was also a period of probation for new staff with regular reviews although we found the reviews were not always occurring as planned by the provider.

Supervision processes also required improvement. This was known by the management team and group supervision had occurred with one to one meetings planned for staff and an annual appraisal. However, staff feedback was mixed regarding how supported they felt by the provider. Some staff said morale was low after experiences last year. They told us a senior manager had held discussions with staff about their concerns and they had expressed needing time to reflect and recover. They did not feel listened too when a very complex emergency admission was taken. Other staff were more positive and they told us they had felt supported by the new regional manager, things were improving and they appreciated having another registered manager from a different service come in to help.

Following the inspection we spoke with the nominated individual about these areas and the potential benefits of staff receiving clinical supervision to address issues related to morale and training from specialists to help them support people's individual needs. Staff shared they had a positive a team meeting recently with a manager from another home who was supporting the acting manager whilst recruitment to a

permanent manager occurred, "Great team meeting with [X], re grouped, drawn a line in the sand, it was rallying the troops."

An action plan was submitted following inspection feedback. This advised what would be put in place to ensure all staff received support, "To put in place a helpline for staff who feel they require a place to discuss personal feelings. To consider specialist clinical supervision for staff regarding some of their experiences in supporting a difficult service users. To arrange for a specialist psychologist to support staff around the experiences they are encountering with people they have worked with and people they are currently working with. Those supervisors are trained to achieve supervision and appraisal that is developmental and meets the organisation's needs. To ensure that supervisions of all staff are booked for the year. All appraisals for staff are booked for the year."

Prior to the inspection professionals gave examples of visiting the service and although appointments had been planned in advance, their arrival at Kanner was sometimes unexpected. We spoke to the acting manager about communication within the service and the systems in place to ensure these were documented and shared with all staff. Computer calendars were used and a team diary but staff could not access each other's calendars and in the event of absence these systems had failed. The acting manager was addressing this to minimise the risk of this occurring again.

Professional feedback received also said that despite planned visits essential care records had not been available and accessible by staff. The acting manager advised all staff have access to people's records on the system used but staff advised, "There were times we were not well organised, this has improved." In November 2017 the Commission received concerns from a relative that essential information they required for their relative's transition to a new service had not been forthcoming. We spoke with the acting manager who advised this was an exceptionally difficult period and unusual departure from the service. They told us transitional paperwork and staff to support people to settle into their new homes or services was usually available.

People's files held communication guidelines. This showed how each person was able to communicate and how staff could effectively support individuals. People's "Hospital Passport", which could be taken to hospital in an emergency, detailed how each person communicated to assist hospital staff to understand people. Staff demonstrated they knew how people communicated and encouraged choice whenever possible in their everyday lives. However, people's care plans were not currently in an accessible format. The acting manager was aware of this being an area which required improvement.

There was a large communal kitchen at Kanner. People were able to access this with staff support but usually ate in their own flats. People at the service required staff to offer healthy, nutritious meals as they were not always able to make these decisions for themselves. Some people were prone to weight gain due to their health needs and medicines they were on. Staff were keen to change the menu and make it healthier. There were 26 hours of a chef vacancy at Kanner at the time of the inspection. Staff always cooked at the weekend, but at the time of the inspection they were supporting the part time chef (16 hours) whist recruitment occurred.

Staff said meals were high fat convenience foods such as chicken nuggets and pies, and consisted of cheap meals like scrambled eggs on toast. They didn't have enough bacon at lunch to make everyone a bacon sandwich. The menu on display did not match what was on offer for lunch during the inspection. The menu consisted largely of convenience oven foods for example pizza, chicken nuggets and pasta dishes. The menu had not been devised with the involvement of people or their families but staff advised they knew people so well they would not cook anything people did not like. Staff we spoke with told us the food budget had been

cut to £240 a week (this budget was for the four people at the service and staff supporting their care on long shifts, on some days we were told there night be a total of 10 —15 people and staff eating on this budget). Staff told us they were buying the cheapest meat, "[X] costs [X – a very large sum] a week to live here and gets value tin soup".

We spoke to the provider about this after the inspection who told us they felt the food budget was ample for this many people. We requested they discuss this with the acting manager. The service had been buying food as required, but had recently arranged on line food shopping and delivery. The action plan submitted to the Commission advised people's nutritional intake and the budget was to be discussed, "To communicate what is required within the service that meets service users' needs and those staff that have been told that as part of their contract they also can have a meal. To involve service users within the process of choosing and ordering of food."

People's health was monitored to help ensure they were seen by appropriate healthcare professionals to ensure their ongoing health and wellbeing. People's weight was monitored to encourage people to maintain a healthy weight in their best interests although we found changes to the menu would support a healthier lifestyle. People's care records detailed that a variety of professionals were involved in their care, such as specialist nurses, occupational therapists and GPs. Annual flu vaccines had not been considered over the winter and staff told us several people at the home had been unwell over Christmas. The management team advised this would be discussed with people's doctors next year.

Staff had completed training about the Mental Capacity Act 2005 (MCA) and knew how to support people who lacked the capacity to make decisions for themselves. Staff said people were encouraged to make day to day decisions. Where decisions had been made in a person's best interests these were fully recorded in care plans. Records showed independent advocates and healthcare professionals had also been involved in making decisions. This showed the provider was following the legislation to make sure people's legal rights were protected.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had a policy and procedure to support staff in this area. The previous registered manager had liaised with appropriate professionals and made applications for people who required this level of support to keep them safe. These were in place.

People were not always able to give their verbal consent to care, however staff explained how they would verbally ask people for their consent and offer pictorial choices if appropriate prior to supporting them, for example before assisting them with their personal care tasks or activity. Where people had unwise choices, for example clothing in extreme weather, the acting manager offered choice by suggesting a limited amount of sensible clothing to keep them warm in their best interests.

People lived in a service which was undergoing refurbishment to meet their needs. During the inspection the service was cold, radiators were not working efficiently. This had been identified by the new provider and heating quotes were being obtained. Some people's rooms were very bare, we saw others where furnishings were ripped and looked dated, and worn. The communal lounge was uninviting and bare. The only information on the walls being a staff noticeboard and there were large holes in the wall where the television had been removed. We were told this space might be used for a different purpose in the future as most people relaxed in their own lounges in their flats. The upstairs staff office and staff overnight room were dated and unwelcoming, drawing pins held the curtain up in the staff bedroom. These rooms were also

due to be refurbished. Play equipment in the garden, for example the trampoline which people could access required new safety netting. A new key fob system had been put in place; this meant staff were no longer holding people's doors closed when they needed time in their flats. A new kitchen was also planned.

The lack of appropriately maintained environment is a breach of Regulation 15 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider's action plan confirmed the heating and environmental improvements which would be made to people's home and staff accommodation.

Good

Is the service caring?

Our findings

The staff continued to provide a caring service. People had built strong relationships with the staff who worked with them. People appeared comfortable with the staff working with them and there was a relaxed and calm atmosphere in the service.

People were supported by staff that were both kind and caring and we observed staff treated people with patience and compassion. We heard and saw plenty of laughter and smiles. Staff were attentive to people's needs and understood when people needed reassurance, praise or guidance. Professionals all commented on the caring attitude of staff.

People representatives were involved in decisions about their care. People had their needs reviewed and staff from the service who knew people well attended these review meetings. Personal representatives, for example family members or advocates and health care professionals also attended where possible.

Staff knew people well and understood people's communication styles. Staff were able to explain each person communication needs, for example by the noises and expression they made to communicate whether they were happy, sad, frustrated or becoming anxious. Staff clearly understood people's nonverbal communication and explained to us how they knew by people's body language, behaviours and facial expressions whether they were content. Staff were mindful of people's different characters, for example those who liked their own space and fresh air and those who preferred more interaction with staff.

People had access to individual support and advocacy services. This helped ensure the views and needs of the person concerned were documented and taken into account when care was planned.

People's independence was respected. For example, staff explained how they encouraged people to participate in household tasks such as room cleaning, laundry and kitchen responsibilities. This helped people maintain and develop their skills for independent living and feel valued. Staff understood people's individual needs and how to meet those needs.

People's privacy and dignity was promoted. Staff usually knocked on people's doors prior to entering their rooms although we did observe this was forgotten on occasions. Staff used their knowledge of equality, diversity and human rights to help support people with their privacy and dignity in a person centred way and gave examples of how they did this in a person centred way. People were not discriminated against in respect of their health needs and staff wanted people to enjoy a good quality life. People living at Kanner were currently single but staff advised they would support people with relationships and needs related to their sexuality as they arose. People's care plans were descriptive, known and followed by staff.

Special occasions such as birthdays were celebrated with party food, cakes and gifts.

The staff team were unsure of the organisation's values and felt this was an area they would like to develop, however their own individual values as staff were demonstrated the week of the inspection when staff

walked to work in the snow to ensure people were cared for, other staff spent the night at the service when staff had been unable to get to the work. The staff team demonstrated genuine care and affection for people. This was evidenced through our conversations with the staff team, for example when one person had been unwell last year; staff supported them around the clock in hospital which had been a challenging time for the person and staff.

People, where possible, received their care from the same staff members. This consistency helped meet people's behavioural needs and gave staff a better understanding of people's communication needs. It supported relationships to be developed with people so they felt they mattered. Staff told us improving communication amongst themselves had been a priority to ensure people received consistency and care in the same way across the staff team. They worked closely to share information within people's teams, used handovers and debriefs to ensure all staff knew what was happening with people. This had improved outcomes for people and reduced the likelihood of particular incidents. We spoke with staff about the language they used at times, often unconsciously and looking at more person centred and less institutionalised vocabulary. For example staff referred to people's flats as "units", people's "baseline" was referred to, and hospital terminology was used for example, "absconding."

Requires Improvement

Is the service responsive?

Our findings

There was an assessment process prior to people coming to live at Kanner. We spoke with staff about the admission process. Staff were in the process of getting to know the person to facilitate a smooth transition but it was not apparent that either admission had considered the current mix of people living at the home. The last admission to the service was a verbal, active person with very different needs to the three other people living at the service. We were concerned a new admission was being considered when there was not a permanent manager in post, areas which required improvement, and staff and relatives described themselves as in a period of, "limbo." We raised this with the provider to consider.

People's care plans detailed how people needs should be met in line with their wishes and preferences, taking account of their social and medical history, as well as any cultural, religious and spiritual needs. Where required care records detailed the restrictions people had in place and gave guidance for staff. However, they were not easy to navigate particularly where there was significant information about people. Relatives told us they had not been involved in developing care plans although staff said their views were incorporated into care planning.

Reviews required improvement. We were informed that people had reviews by their funding authorities but there was not a regular system in place to ensure this happened within the service on a regular basis. This would support the service to know whether the care they are providing, activities and support is having a positive outcome on people or whether it requires changing.

People did not have care plans in an easy read format where possible, for example by using pictures. We were told this could be developed. Staff monitored and responded to changes in people's needs but we were concerned we had to prompt staff to consider a robust plan for one person who would have been at risk in the adverse weather. With other people, staff were now using forms to monitor people's behaviour or arousal charts so they were able to respond better and notice patterns.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The information we saw around the service was not in a format all people could understand. The menu in the kitchen was in words which not all people at the service would be able to read.

A complaints procedure was not visible in an easy read, pictorial format. One family who had used the complaints process had been disappointed. The acting manager however explained they would act in an open and transparent manner, apologise and use the complaint as an opportunity to learn. Staff told us that due to people's nonverbal communication they knew people well and worked closely with them and would monitor any changes in behaviour. People had relatives, advocates or paid representatives appointed to ensure they had their voices heard.

There was a lack of regular reviews, a lack of evidence of involvement in care planning and lack of records in an accessible format for people using the service is a breach of Regulation 17 of the Health and Social Care

Act (Regulated Activities) Regulations 2014.

People received individual one to one or two to one care. People's communication needs were assessed and met and staff told us how they adapted their approach to help ensure people received individualised support. For example, social stories, visual choices to assist people, and some staff had undertaken Makaton training. Speech and language specialists had been involved to support staff to develop skills to communicate with people by use of key words, pictures, simple sign and repetition of questions to check understanding.

People took part in a range of activities bit it was unclear how often these occurred. We heard how people enjoyed spending time going swimming, for drives, to the local shops, adventure parks and some had been on holidays with staff. People had their own cars which helped them get out and about with staff as the service was in a rural location. Staff told us some people's activities were not always person centred or of benefit to them, for example the food shop. Other people were receiving support and had programmes in place from specialist services to work towards going out again. Staff were working with professionals to look at increasing their opportunities. One staff told us they'd love for him to have a "man shed". This was an area the service recognised required improvement. On the day of the inspection people were enjoying a variety of activities they like to do including music, gaming and one was being supported by staff to go and buy their toiletries.

Although people at the service were young, end of life care had not been considered. Some people due to their health were at risk of premature death. This was an area the acting manager agreed required development.

Requires Improvement

Is the service well-led?

Our findings

In April 2017, Modus Care (Plymouth) Ltd was acquired by Salutem Healthcare. The registered manager left in July 2017. A temporary manager was appointed for a short period but they also left. At the time of the inspection a staff member was acting up as manager whilst recruitment occurred. The week prior to the inspection, a registered manager from another of the provider's services was asked by the provider to support Kanner Project. We were informed following the inspection an appointment had been made to the registered manager vacant post.

We found there was not a clear set of known organisational values in place which staff were aware of and working to put into practice. Basic information such as the admission criteria was not clear across the staff team. Staff morale was mixed and processes to support staff such as supervision had lapsed. Not all staff felt supported and valued by the provider. However, we observed a close knit and supportive staff team. There was an open culture within the staff team and an awareness of where improvement was required. Staff were keen to share the past experiences, current challenges and looking hopeful towards future changes. They had found the recent staff meeting an opportunity to "draw a line" and move forward. The "acting manager" had an open door policy and we observed staff came and accessed support readily.

The provider's regional manager had been supportive to the service but unable to visit the home in recent months. A new interim regional manager was now visiting the service and had supported staff at people's review meetings. An action plan was being drawn up the week of the inspection to address areas the provider felt required improvement.

Policies and procedures were in place but these did not always reflect latest NICE (National Institute of Clinical Excellence) standards for example the medicine policy. Policies, procedures and records that people might need were not in a format they could easily comprehend.

House audits were completed but there was a lack of a governance system based upon best practice. Audits were more like checks, for example the cleaning check list. A medicine audit was in place but had not identified issues related to key safety or the safe recording of controlled drugs. There was not a robust system in place to analyse and learn from incidents and safeguarding. Admission criteria processes required reviewing to ensure staff had the skills they required and the service was safe for new people. The acting manager had developed a system to monitor supervision and appraisals for staff and there was a training matrix which highlighted when staff were out of date in certain areas.

High quality care was compromised by a lack of involvement of people where possible and their relatives in developing the service, for example in care planning, food and menu development, refurbishment plans and recruitment processes. Although daily records were comprehensive the lack of analysis and goal setting meant it was difficult to review people's progress and outcomes.

Although there were good handover processes in the service, communication failures had occurred and professionals shared how the service did not always know they were visiting.

A system of remaining up to date and sharing best practice required developing and monitoring to enhance the quality of care people received and support the staff to stay abreast of changes.

There was some partnership working, for example with people's review teams and the local learning disability services. The acting manager was attending the local authority leadership and management course and sharing good practice at these days. Peer visits across services had occurred allowing the view of a "fresh pair of eyes." Attendance at the local dignity and care forum meetings was more frequent than in previous years.

Following the inspection we spoke with the provider about the areas the inspection had identified required improvement. We also shared inspection feedback with the local authority commissioners and safeguarding team.

The lack of Good Governance arrangements was a breach of Regulation 17 of the Health and Social Care Act (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 12 HSCA RA Regulations 2014 Safe care and treatment This is a breach of Regulation 12 (1) (2) (a) (b) (c) (i) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to people were not always assessed and these risks were not always mitigated in a timely way. Staff providing people's care did not always have the competence, skills and experience to do so safely. Timely care planning to ensure the health, safety and welfare of people had not always occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment This is a breach of15 (1) (e) All premises and equipment used by the service provider must be properly maintained.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) Systems and processes were not established to assess, monitor and improve the safety of people using the service; assess and mitigate risks; seek and act on feedback and records were not in a format people could understand or easily accessible for people and family. Systems to evaluate and improve practice required improvement.

The enforcement action we took:

We issued the provider with a warning notice for Regulation 17.