Alpha Medical Care Limited

Alpha Community Care

Inspection report

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Ratings

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

Overall summary

Alpha Community Care is a care home which provides accommodation and personal care for up to four people with learning disabilities and complex needs such as autism.

At the time of our inspection there were four people living in the home. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We previously inspected the service on the 10 February 2014. At that time the service was meeting the regulations inspected.

Summary of findings

The inspection took place on the 14 and 15 January 2015 and was carried out in response to concerns raised with us by the Local Authority's contracts monitoring team.

Relatives were generally happy with the care provided. However we found people's safety was being compromised in a number of ways.

The provider did not have a system in place to assess the number of staff needed and there was not enough staff to support people and meet their needs. As a result staff worked excessive hours including day and night shifts in succession.

Risks to people and others were not always identified or managed to promote their safety. Care plans lacked detail and did not address people's identified needs. The home worked in isolation and had no community links established. People did not have activities provided for them which met their individual needs.

Staff were not suitably inducted and trained to meet people's specialist needs. They did not receive supervision in line with the provider's policy on supervision and an annual appraisal of their performance was not taking place. The required recruitment checks were not always carried out on staff before they commenced work at the home.

We were told people did not have capacity to make decisions around their care and support. Decisions on their care were not made in a best interest meeting as is required by law. People were prevented from leaving the house unescorted and the doors were kept locked. Deprivation of Liberty Safeguard applications (DoLS) had been submitted to the Local Authority for approval. DoLS aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. In the absence of the DoLS assessments being carried out staff continued to keep the door locked without recognising it was restraint and there were no care plans or risk assessments to support the decision.

Staff were trained in how to safeguard people from abuse and were aware of the process to follow in the event of any such allegation. Staff practices indicated staff were not safeguarding people as they did not provide person centred care and failed to involve people in decisions and choices and promote their independence in relation to their daily care. There was no system in place to question staff practices to ensure people were safeguarded from potential abuse.

There were no quality monitoring systems in place to ensure the service was being effectively monitored and managed. Accurate records were not maintained and up to date polices were not available to support staff in their practice. The registered manager was not up to date with current legislation and best practice and therefore was not able to develop their staff team to promote safe person centred care.

People were provided with three meals a day but the menus indicated the meals were not varied and balanced. Staff supported people with their meals. Aids were provided to enable people to eat independently and mobilise around the home.

Relatives told us they thought staff were kind and caring. One relative commented "It feels like the staff are an extension to our family". We observed staff were kind but they had minimal engagement and communication with the people they supported. They did not use any communication aids to engage with people as was outlined in people's communication passports included in their care plans.

Infection control was not being managed which put people at risk of cross infection and contamination. The home was clean but was not adequately maintained to provide a safe and homely environment for people. Health and safety checks of the property were not taking place to ensure it was safe and fit for purpose.

Prescribed medicines were safely administered but there was a lack of guidance for staff in relation to the administration of over the counter medicines and as required medicines. People's health needs were met and people had access to health professionals such as GP's, Dentists and Opticians. They had no input from other health professionals such as dieticians, occupational therapist or psychologist. Staff supported people to attend appointments and records were maintained of the visit and outcome.

Summary of findings

People's records were kept secure and their confidentiality was upheld as discussions about them took place in private. Systems were in place to deal with complaints and relatives told us issues raised were always addressed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which from the 1 April 2015 is 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Sufficient staff were not available to ensure people's needs were safely met.

Risks to people and others were not always identified or managed to promote their safety and well-being.

Staff were trained in safeguarding vulnerable adults but their practices indicated they failed to safeguard people.

Inadequate

Is the service effective?
The service was not effective.

Staff were not suitably inducted, trained, supervised and appraised to ensure they provided safe care to people and worked to best practice.

Suitable arrangements were not in place for obtaining consent from people in line with legislation.

Meals were not varied or nutritionally balanced. People had access to a GP, dentists and opticians but had no involvement from specialist professionals such as dieticians, physiotherapist and psychologists to ensure their needs were kept under review and met.

Inadequate

Is the service caring?
The service was not caring.

People were not provided with information to enable them to contribute to decisions on their care.

People's independence and involvement in the home was not promoted.

Staff were kind and seemed to understand people's needs but did not communicate with them using their preferred methods.

Inadequate

Is the service responsive?
The service was not responsive.

People's care plans lacked detail as how people's identified needs were to be met.

Individual programmes of activities were not in place and people participated in group activities as opposed to individual activities.

Systems were in place to deal with complaints. There was no system in place to gather feedback from people, relatives or others involved in their care to ensure issues were raised and addressed.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The service was not effectively audited and managed to ensure people got the required care.

Policies and procedures to support staff in their practice were out of date and not in line with current legislation.

Records were not kept up to date and accurate.

Alpha Community Care

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.

This inspection took place on 14 and 15 January 2015 and was unannounced. This meant staff and the provider did not know we would be visiting. The inspection was carried out by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR) The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed the previous inspection reports of the home and other information we held about the home. We looked at a recent local authority contract monitoring report and the issues raised in this triggered our inspection. We received feedback from one health professional involved with the home.

People who used the service were unable to communicate verbally with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with the registered manager and three care staff. We also spoke with two relatives by telephone after the inspection. We looked at a number of records relating to individuals care and the running of the home. These included four care plans, medicine records for four people, staff duty rosters, shift planners, two staff recruitment files, five staff training and supervision records.

Inadequate

Is the service safe?

Our findings

Relatives told us they thought their relatives were safe at the service. They felt however the staffing levels could be better to enable people to go out more and be adequately supervised.

We found there were not sufficient staff available to keep people safe. Staff told us they thought the staffing levels were alright but at times could be better. One staff member told us more activities could be provided if the staffing levels were better. Staff said they did not feel pressured by the provider to work extra hours and it was their choice to do so. The staffing rota indicated there were two staff on duty during the day, one staff member at night and agency staff were used to cover shortfalls. However, the rotas did not reflect the actual staff on duty or the hours they worked. The registered manager told us they were unaware that the rota needed to reflect the actual staff on duty.

We identified that a care worker on the early shift had been on duty since 9 pm the previous night, this was not recorded on the staff rota. The care worker confirmed they had worked the waking night shift and were working until 2.45 pm in the afternoon. This meant that the care worker had been in work for a total of 17 hours and 45 minutes. During the period from 14 December 2014 to 14 January 2015 we identified a further 17occasions when staff worked a shift before or after completing a waking night shift. On four of those occasions staff worked a night shift followed by a long day which was a total of 24 hours. There was no opportunity for staff to have a suitable break and when on night shift they worked 11 hours on their own. We saw those staff were responsible for medicine administration and driving people in the mini bus. This practice was unsafe and put people at risk of not being supported by staff who were suitably alert. The registered manager told us this would not happen in the future.

The service was not able to demonstrate that staffing levels were calculated to make sure people's needs were met. Records showed occasions where two people went on social leave for a period of time. During these times only one staff member was on duty to support the remaining two people. We saw in care plans that one of these people required one to one staff support to promote their safety. It was not clear how this would be provided when one member of staff was supporting two people at the service. This had the potential to put that person at risk of not having their needs met.

The registered manager told us the staffing ratio was two staff to one person as this was what they were funded for. We asked to see the dependency tool that was used to calculate staffing levels. The registered manager told us they did not have one in place and did not know where to access one to ensure they had sufficient staff on duty to meet people's needs safely.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider failed to ensure that at all times there were sufficient numbers of suitably qualified skilled and experienced staff employed and available to carry on the regulated activity.

Risks to people were not being appropriately managed. One person's care plan identified they were at risk of self-harming, epilepsy seizures in the bath, dehydration and needed to take care with knives and forks. Another person's care plan identified they had recently been diagnosed with a medical condition. Risk assessments and management plans were not in place to address and manage these risks to promote people's health, safety and welfare.

Where risk assessments were in place they were implemented in 2007. We saw they were not person centred in that each person had risk assessments for the same areas of risks for example risks assessments in relation to dry skin, finances and helping with tasks. We saw in all four care plans viewed that people had a history of behaviour that may challenge. Two people had a risk assessment in place to support them with these behaviours. However they were not detailed and specific enough to ensure staff were consistent in their approach and in the management of the challenging behaviours. The other two people did not have risk assessments in place to provide guidance to staff on the management of the challenging behaviours they presented with.

Staff were aware of the reporting process for any accidents or incidents that occurred. We viewed accident and incident records. They were completed by the staff member

who witnessed the accident and signed off by the registered manager. They did not always indicate if action was taken or required to prevent reoccurrence such as changes to the persons care plan or introduction of a risk assessment to manage the risk. For example, one person had a recent fall. There was no risk assessment put in place to manage this to reduce the likelihood of further falls.

We read in one person's care plan that they needed staff to assist them with moving. There was no up to date moving and handling assessment in place. Another person had a moving and handling assessment in place which was not fully completed to indicate the level of risk. It was reviewed to say no change and made no reference to a mobility aid which we observed the person using. The care plan identified they used a hoist but the moving and handling assessment made no reference to this or when it was required. This had the potential to put people at risk of not being moved and handled safely.

Staff told us they were aware of risks to people and these were discussed in team meetings. They said any changes in risks were communicated at handovers. We looked at staff meeting minutes. It was recorded that discussions had taken place on people's care and progress however this had not been transferred into individual risk assessments to safeguard people.

A general work place risk assessment document was in place dated April 2009. The registered manager told us that up to date work place risk assessments and a risk assessment policy were not in place. This had the potential for risks not to be identified and managed to promote staff and people's health, safety and welfare. A lone working policy had recently being implemented and there was a lone working risk assessment for each staff member to promote their safety.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a)(b-h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the registered person failed to ensure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

The service was in need of decorating and updating. The flooring in the toilet, bathroom, kitchen, dining room and en-suite was torn and had lifted around the edges. This had the potential to place people at risk of tripping. The carpets in people's bedrooms were worn and in one person's bedroom the carpet had frayed and another's was stained. The registered manager had obtained a quote for the flooring and carpet and this was due to be replaced.

We saw cracks on walls and ceilings and there was a damp patch in the ceiling. Walls throughout the home were stained and in need of repainting. Towel rails and toilet roll holders were coming off the wall and kitchen cupboards were loose and did not close properly. The registered manager told us they had no refurbishment plan in place to ensure the home was kept maintained, refurbished and fit for purpose. We asked how maintenance issues were managed. The registered manager told us any maintenance issues were recorded in the communication book and they used a local handyman to do the required work. Records were not maintained to support this.

We asked to see the home's contingency plan to outline what provision was in place in the event of a major incident at the home such as fire, flooding, electric, gas or water failure. The service had a business continuity plan which was reviewed in April 2013. The emergency telephone numbers were contained within the document but were not easily accessible. The plan did not outline a safe place that people could be taken to and cared for until such time as the service became habitable again.

Staff were responsible for carrying out water temperature checks. These were checked and recorded weekly. The records indicated occasions where the water temperature exceeded 44 degrees centigrade which is considered by the Health and Safety Executive to be maximum safe temperature for water outlets in care homes. The registered manager said this would have been adjusted but the records did not indicate action was taken and this was monitored. Staff checked and recorded fridge, freezer and food temperatures. No other health and safety checks were carried out and a health and safety audit had not been completed. The registered manager was unable to evidence when or if a legionella test had been carried out. Health and safety policies were not available to staff to ensure they promoted safe practices and worked within Health and Safety legislation. We informed the local authority's environmental health department of our findings.

The fire equipment was serviced in May 2014 and portable appliance testing took place annually. We saw weekly fire checks and quarterly fire drills took place. A fire risk

assessment was in place. However, people did not have personal emergency evacuation plans in place to ensure people were safely evacuated in the event of a fire. We saw fire doors in bedrooms had been propped open. The registered manager told us people using the service liked to keep their bedroom doors open. This was not done using a suitable approved door closure to safeguard people in the event of a fire.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the registered person failed to ensure that people using the service and others were protected against the risks associated with unsafe or unsuitable premises.

Staff were responsible for administering medicines. There was an undated medicines policy in place to support staff practice. The policy did not provide guidance on how homely remedies and "as required" medicines were to be managed. Homely remedies are medicines that can be bought over the counter. We saw homely remedies were in use. These had not been agreed and signed off by the GP or supplying pharmacist to ensure they did not interact with people's prescribed medicines. One person's care plan indicated they had an allergy to a particular medicine. It was not recorded on the person's medication administration record (MAR) and had the potential for the person to be prescribed medicines which they were allergic to. We were told staff were trained annually in medicines administration. The training matrix provided confirmed that. We saw medicines were stored safely. We looked at medicine administration records for four people. There were no gaps in administration and medicines were administered as prescribed. Systems were in place to record medicines received into the home and those that had been disposed of. There was no system in place to audit medicines to ensure safe medicine practices were maintained.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person failed to ensure people were protected against the risks associated with the unsafe use and management of medicines.

Staff told us they had received training in safeguarding adults. This was confirmed by viewing staff training records. None of the staff had attended the level 2 safeguarding training with the Local Authority. This training provides guidance on what is abuse and reporting procedures. Staff told us they would report any suspicions of abuse and said they were confident any such allegations would be properly investigated. They were aware of the whistle blowing procedure and who to contact outside of the home if their concerns were not taken seriously. The provider had a prevention of abuse and safeguarding policy in place dated 2007. This outlined the types of abuse and how an allegation of abuse was to be dealt with. The policy was not updated to reflect the Care Quality Commissions contact details. The home had a copy of the local authority's safeguarding of vulnerable adults policy which was dated 2013. There was a flow chart on the notice board in the office to provide guidance to staff on what to do in the event of a safeguarding alert.

It was of concern staff did not recognise their own practices were outdated in that people were not provided with person centred care as their individuality, choices and independence was not promoted. Potentially this placed people at risk of institutionalised abuse. We saw people were being restrained in that the home was locked and they were prevented from leaving. This restraint was unlawful and there was a delay in Deprivation of Liberty Safeguards applications being made. DoLS make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. Staff failed to recognise that the practice of locking the doors was a form of restraint and failed to safeguard people against the risk of abuse.

We read in people's care plans that they had a history of behaviours that may challenge such as hitting other people or staff and using equipment to throw or hit other people with, yet no safeguarding referrals had been made to the local authority safeguarding team in respect of those behaviours. No notifications of abuse had been made to the Commission since the service was registered in 2011, which you would expect from a service with people who challenge. Whilst staff were trained in safeguarding vulnerable adults the training did not provide them with the knowledge and skills to safeguard people against the risk of abuse.

Inadequate

Is the service safe?

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to make suitable arrangements to ensure people were safeguarded against the risk of abuse.

The home did not have an infection control policy in place. The registered manager told us they were not aware of the code of practice on the prevention and control of infections. This is guidance from the department of health on how infection control should be managed to prevent and control infections. There was no infection control audit or risk assessments in place and the service did not have an identified infection control lead. Staff told us they were all responsible for infection control and they had received training on the subject. We saw in the training matrix provided staff had competed on line infection control training. The registered manager told us staff used different colour coded mops and cloths for cleaning different areas of the home but guidance was not provided for staff to ensure this practice was consistently maintained. Staff were not aware how soiled laundry should be managed in that it should be placed in red bags to prevent cross infection. A cleaning schedule was in place but there were no records to indicate tasks had been completed and by whom. The registered manager told us they could see when cleaning tasks were completed. They confirmed after the inspection cleaning tasks were recorded and signed off on the shift allocation sheet. The lack of policies, guidance and protocols had the potential to put people at risk of cross infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person failed to have an effective operation of systems in place to assess the risk of and prevent, detect and control the spread of a health care associated infection.

We spoke with the newest staff member. They told us they had completed an application form, attended for interview, references were sought and a Disclosure and Barring Service (DBS) check was carried out before they started work at the home. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with adults. This was confirmed in records we viewed. When agency staff were used at the service, the agency had provided evidence that checks had been made to ensure they were safe to work at the service.

One staff member had recently been employed as a bank care worker, having previously worked at the service in 2011. The registered manager told us they had advice from the employment law service on what checks they needed to carry out on that staff member and an email was available to confirm the advice given, which was not in line with Schedule 3. As advised an application form had been completed and a DBS check had been carried out. No references had been obtained to confirm satisfactory evidence of conduct in previous employment in the four years since they had previously being employed. The registered manager told us the staff member had come to the home and had an informal discussion with them. However, a record of that discussion was not maintained. The registered manager agreed to address this.

Inadequate

Is the service effective?

Our findings

Relatives told us they thought some staff were better trained than others in that some staff seemed to have a better understanding on how to support people with their needs. A relative commented "I don't know if staff have much understanding of people's communication needs but it seems to work".

Staff told us they felt suitably inducted and trained to do their job. The newest staff member told us they had worked alongside other staff in getting to know people who used the service. The provider's policy on induction indicated all staff would have a structured induction within six weeks of being in post. We looked at the induction records for the newest staff members. There was no induction record for the bank worker. The registered manager told us the staff member had previously worked at the home in 2011. They said they had a recent induction but they had failed to record it. We saw the other staff member had completed an induction which was not in line with the common induction standards. The common induction standards are the standards staff working in adult social care need to meet before they can safely work unsupervised. The induction undertaken by staff did not cover the essential standards of quality and safety and referred to the Commissions previous regulatory body Commission for Social Care Inspectorate (CSCI). We were told agency staff were given an induction to the environment and introduced to people who used the service and made aware of their needs. There were no induction records maintained to confirm agency staff had been suitably inducted to people who used the service and into the home.

We were provided with a training matrix which indicated staff were trained in fire awareness, first aid, food hygiene, health and safety, medication, safeguarding, and diabetes. Four out of the eight staff were trained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Further training on these topics was booked and scheduled to take place. Care plans indicated that people sometimes demonstrated behaviours that challenged the staff and other people. The strategy outlined in people's care plans for managing it was that staff were trained in supporting people with behaviours that challenged. The training matrix provided and the records viewed did not show staff were trained in this area.

Two people required staff to support them to move safely. Staff had completed on line moving and handling training but had not attended practical moving and handling training to ensure they were trained and competent to move people safely.

People's care plans indicated they used Makaton (Makaton is a communication system which uses speech supported by signs and symbols) as a means of communication and some people had a diagnosis of epilepsy. Staff had no specialist training in learning disabilities, autism, epilepsy or Makaton to enable them to have a better understanding of the people they supported. Staff were responsible for administering medication. Whilst they were trained in medication administration there was no competency assessments completed to ensure staff had the required skills to administer medication competently and safely.

Systems in place for developing and supporting staff were not effective. Staff told us they received regular supervision meetings with their manager and had the required support. The provider's supervision policy indicated supervision meetings were to be held every three months. Staff supervision records showed supervision meetings had not been taking place in line with the provider's policy. The registered manager confirmed they were aware supervision of staff had not been taking place. They said they had recommenced supervisions and two staff had supervision in January 2015. We saw records to support this. The registered manager told us new staff had a review of their performance after three months. There was no record maintained of this and a new staff member's supervision records made no reference to it either. We saw annual appraisals of staff were not taking place either. One staff member had an appraisal on file dated April 2012.The other three files viewed had no evidence of an appraisal even though they had been in post for many years.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the registered person failed to have suitable arrangements in place to ensure staff received suitable training, supervisions and appraisals.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected.

Inadequate

Is the service effective?

When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

We were told the four people who lived at the home did not have the capacity to make decisions. People's care plans did not indicate this. There were no mental capacity assessments on file to indicate how decisions in relation to the care and treatment of those people were made. Relatives had consented to the use of homely remedy medicines but the registered manager did not know if relatives had Power of Attorney for people's welfare or not. Records showed that people attended for annual influenza vaccinations, dental and medical treatment. Treatment was given without considering whether it was in the person's best interest as is required by law.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. It ensures the service only deprives someone of their liberty in a safe and correct way and this is only done when it is in the best interest of the person and there is no other way to look after them. All four people were unable to leave the home unescorted and the front door was locked to prevent them from leaving. A DoLS application was made to the local authority in December 2014. The registered manager was made aware of the need to make the application at a person's annual review in July 2014 but had failed to complete those assessments in a timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person did not have suitable arrangements in place for obtaining consent from people who used the service in relation to their care and treatment.

We observed lunch. We saw people were given good portion sizes and the meal was nicely presented. People were provided with support to eat their meals and suitable protective clothing was used. People were provided with three meals a day and records were maintained of meals eaten. We saw people's care plans made reference to the support people required at meals and equipment was provided to promote independence. Records showed people were weighed monthly and records were maintained. Staff were aware of who required special diets and this was promoted.

We were provided with a copy of the menu over a two week period. The menus seen indicated vegetables were only provided with the main meal on Sundays and meals were not varied. The home had no involvement from dietitians and had not considered how meals could be more nutritionally balanced and varied whilst meeting people's preferences. Staff told us the meals were developed around people's likes and dislikes which made it more difficult to make them varied.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because people were not protected against the risks of inadequate nutrition.

People had access to health professionals to meet their specific needs. We saw records were maintained of appointments with professionals and the outcome of those visits. The records indicated people had access to medical and dental treatment but there was no evidence specialist's professionals such as dietitians, speech and language therapists, occupational therapists, physiotherapist or psychologist had any involvement with the service. The registered manager did not think those specialists were required at the current time. There were annual reviews of people's care and progress. Staff supported people to see a doctor and went to hospital appointments with them. Relatives told us staff kept them informed of changes in people's health and sought medical input if required. A relative commented "Communication with the home is good, we can visit at any time and health issues are addressed quickly". A health professional involved with the home commented that people seem very well looked after and they had no concerns about the care offered.

Inadequate

Is the service caring?

Our findings

Relatives told us they thought staff were kind and caring. One relative commented "It feels like the staff are an extension to our family".

We observed staff engaging with people. We saw they were kind, considerate and seemed to have an understanding of people's needs. However, we saw staff were more task orientated than offering a person centred approach. This meant staff focused on the completion of tasks such as cooking, washing up, making drinks rather than on enabling and supporting people to be involved.

There was minimal engagement and communication between staff and people. People were not assisted or encouraged to express their views, Staff 'did' for people as opposed to involving them and people wandered in and out of rooms and were not being stimulated.

There was little evidence people were provided with information and involved in making choices and decisions. For example people were not involved in menu planning. There was no evidence objects of reference such as pictures and tasting sessions were used to assist people with choices. We observed people were not offered a drink with their meal and were provided with a drink after they had eaten. They were not asked what they would like to drink. Staff told us they knew what people liked and therefore the menus and drinks were provided around that. There was no evidence available to indicate how staff had found out people's likes and dislikes to ensure they were provided with food and drinks of their choice.

Care plans and practices did not outline how people made a choice of activities or chose what clothes they wanted to wear. We heard people being told "Put your coat on we are going out for a drive". Staff said if the person did not want to go out they would not put their coat on. People were not given the option to go, stay at home or choose another activity. We are not clear what would have happened if a person did not put their coat on as there would not have been enough staff on duty for them to stay at home. Staff told us they did ask people to choose what to do and wear but this was not observed. It was not recorded in their support plans or daily records either to ensure it consistently happened.

We observed lunch. We saw one staff member sat next to a person and encouraged them to eat. The other staff member stood over people whilst they were eating. They asked them if they had finished even though the person was still eating. This indicated people were being rushed and did not promote people's dignity.

During discussion with staff they demonstrated they had an understanding of people's needs but they had not considered what they could do differently to enable people to feel listened to, understood and empowered. People's care plans contained a communication passport. These indicated people communicated using Makaton, pictures, signing, simple words and objects of reference. Throughout the two days of the inspection we saw none of those aids being used to enable people to communicate their needs effectively. Instead we saw staff told people what was happening in relation to meals, activities and personal care and people were not given the time or opportunity to make choices to promote their dignity. These practices did not treat people with dignity and respect.

Staff took responsibility for cooking, cleaning and service user's laundry alongside providing care. We saw people were not given the opportunity to manage their care and they had minimal involvement in those tasks to promote their independence.

People who used the service had an annual review but there was no evidence people or their families were involved in care planning and reviews of care plans to ensure their views were taken into account into how their daily care was delivered. The care plans were developed in 2007 and 2009. They were reviewed annually by the registered manager to indicate "no change". Therefore people's independence was not encouraged and it would indicate they had not progressed or developed during that time.

Resident meetings took place at the service. The outcome of these meetings were recorded in a user friendly way. We saw discussions took place in relation to activities but the minutes did not evidence how people made choices and decisions within the meetings. The home had no involvement from advocates but the registered manager said they were aware how to contact advocates if required. Advocates are independent and can help a person express their needs and wishes, and can weigh up and take decisions about the options available to people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010,which

Inadequate

Is the service caring?

corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not respected and involved in their care.

People's privacy was promoted with personal care provided in private. We heard staff call people by their preferred names. All bedrooms at the home were single rooms. This meant people were able to spend time in private if they wished to.

Staff told us they were aware of their responsibilities in promoting people's confidentiality. We saw people's files and staff files were kept secure and discussions about people and handovers took place in private.

Inadequate

Is the service responsive?

Our findings

Relatives told us they thought staff were responsive to people's needs. One relative told us how their relative had made huge progress since being at the home and that their behaviours had improved which they felt was down to the input from staff.

We looked at four care plans. Care plans and support plans were implemented when people were first admitted to the service and were dated 2007 and 2009. They were reviewed annually to indicate no change. We saw support plans were in place to address some of those needs identified in the plan of care but other needs identified, such as epilepsy, challenging behaviours, daily dental care and support with going out had no support plans or guidance for staff. One person's needs had changed and other health issues had been diagnosed. The person's care plan and review of care plans made no reference to this and how it was to be managed. Staff told us they knew people really well so knew what their care needs were, however the lack of clear, detailed and specific care plans could mean staff were not responsive to people's needs.

Relatives told us they thought people could do more activities and the activities could be more varied. They told us they felt limited activities took place at the weekend which is why they tried to take their relatives on home leave. Staff told us people liked to go on trips out and the majority of staff spoken with felt sufficient activities were provided. The registered manager told us individual programmes of activities were being developed but were not yet in place. One person went to a day centre. When that person was taken to the day centre the other three people had to go to ensure it happened. All four people went to the gateway club every other week. We saw from the activities that had taken place all four people went on trips together such as bowling, meals out, car rides and watching the trains. There was no contingency in the rota to enable people to stay at home if they wanted to or if one person was unwell then all four people would be unable to go out.

There was no evidence available to show people's interests and hobbies were taken into consideration in the development of their programme of activities. Staff were responsible for facilitating in house activities. We saw on day one of the inspection staff encouraged people to be involved in board games but this did not hold people's interest for long. The board games available included block building, puzzles and colouring in books which were not age appropriate and were not tailored to individual's interests, hobbies and abilities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b-h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the registered person had not taken proper steps to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe as care was not planned and delivered to meet people's needs and ensure their welfare and safety.

Relatives told us they would talk to staff if they had any complaints or concerns. Relatives could not recall making a formal compliant but said if they had any issues they told the registered manager and it was dealt with straight away. The provider had a complaints procedure in place which outlined how complaints were to be managed and timescales for investigating and responding to complainants. The policy was reviewed in April 2014 but contained out of date contact details. The policy referred to CQC's previous regulatory body Care Standards Commission Inspectorate (CSCI) and the National Minimum standards. We looked at the complaints log. No complaints were logged since 2010. Whilst resident meetings took place records did not evidence people were asked to feedback on the service provided. There was no system in place to gather feedback from relatives or others involved in their care either to ensure issues were raised and addressed.

Inadequate

Is the service well-led?

Our findings

Relatives told us they thought the service was well led. One relative commented "The manager is approachable and I do feel I can talk to them if I have any concerns". Staff told us they thought the home was well led. They told us the registered manager was approachable and supportive. They felt they could raise issues with the registered manager and issues raised were addressed.

However, we found the home was not being effectively monitored and managed. A quality monitoring policy was not available and no quality monitoring checks were taking place. The registered manager told us they audit petty cash and the time sheets were audited when the staff hours were put on the pay roll. We saw a copy of a completed financial audit but saw the audit of time sheets had not picked up the discrepancies in the rota or dealt with the excess hours staff worked. No other audits of practice were taking place therefore issues in relation to care planning, risk assessments, inductions, training, supervisions and appraisals were not identified and being dealt with. Audits in relation to the environment, infection control, health and safety and medication were not taking place either to promote a safe environment for people.

In view of staff working excessive hours and a combination of day and night shifts we asked what systems were in place to ensure staff were alert and responsive to people at night. The registered manager told us they knew staff were alert as people who used the service slept for short periods and allocated tasks got done. However there was no monitoring taking place to satisfy themselves this was the case to ensure people's safety and well-being.

The registered manager is also the provider therefore there was no external monitoring of the service to ensure the service was being effectively managed in line with Regulations. The registered manager told us they asked relatives to complete an annual survey. The last one was completed in November 2013 and at the time of the inspection none was planned. Relatives told us they did not recall being asked to give their feedback on the service and a forum for doing this such as relative meetings was not in place. They said they came to the annual barbeque and this was an opportunity for them to meet with other relatives, staff and neighbours.

The registered manager told us they do a check of the home on the days they are on duty and check the communication book to ensure that issues are followed through. No record was maintained of the checks carried out. Team meetings took place and records were maintained of those. We saw the team meeting included a discussion on people who used the service and staff told us daily handovers took place to ensure all staff were informed of changes in people's care.

Staff told us they were clear about their roles and responsibilities. However there were no clear lines of accountability and responsibility in the home. The home had a registered manager and a deputy manager. The deputy manager did not have delegated responsibilities and was always included on shifts which would make it difficult for them to take on management responsibilities. The registered manager told us support workers with a National Vocational Qualification (NVQ) or diploma in Health and social care Level 2, were suitably qualified to be left in charge of shifts in the absence of the registered manager and the deputy manager. However, there were no on-going assessments of their competencies to support this decision.

The registered manager worked at the home three days a week. They told us they worked from home the remainder of the week and were always contactable. There was a deputy manager in post. We saw from the rota the deputy manager was not always on duty when the registered manager was not. There was no formal back up or on call arrangements in place. Staff told us they could always telephone the registered manager if they needed advice or call on staff who lived locally to provide extra support if required and if they were available.

The registered manager had some understanding of the key challenges of the service which had been identified as a result of the local authority's commissioner's visit and not through their own auditing. They seemed unaware of the concerns and risks we identified in relation to care plans, risk assessments, people's consent to their care, record keeping, involvement of people in their care and the lack of person centred care.

The home worked in isolation and had no community links other than the day centres people went to. This meant people were not provided with appropriate opportunities to promote community involvement. The registered manager was not an effective role model for staff. This was

Inadequate

Is the service well-led?

because they had not taken account of current best practice and had not made changes to the care and treatment people received in line with the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies. Neither did they have a good understanding of legislation such as DoLS, MCA nor the code of practice on the prevention and control of infections as required in their role as a registered manager.

The ethos and culture of the service was 'to do' for people rather than to enable people. Staff were not providing individualised person centred care. They had not considered how they could involve people more in all aspects of their lives such as making choices in relation to meals, activities and what clothes to wear to ensure they received care which gave them more autonomy over their life. There was no system in place to question practice or to consider what they could do differently to benefit people. During discussion with staff they were unable to identify any areas for improvement. Staff felt they worked well as a team. One staff member commented "We all do our duties and what is expected from us".

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the registered person did not have an effective system in place to enable them to assess and monitor the quality of services provided.

We saw policies and procedures were out of date and not updated in line with current legislation. Where they were reviewed they were not amended to take account of changes in legislation since the previous review. For example the safeguarding policy made reference to CSCI as opposed to CQC.

We saw records were not accurately maintained. This was because the duty rota was not reflective of the staff on duty. People's care plans and risk assessments were not updated to reflect current needs and risks. People's files were disorganised, bulky and contained a mix of out of date information and current information which was not filed in order.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010,which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the registered person did not maintain accurate records in respect of people and the management of the regulated activity.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 9(3)(a)(b-h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to ensure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to make suitable arrangements to ensure people were safeguarded against the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The registered person failed to have an effective operation of systems in place to assess the risk of and prevent, detect and control the spread of a health care associated infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines This was a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to ensure people were protected against the risks associated with the unsafe use and management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs This was a breach of Regulation 14 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to ensure that people were protected from the risks of inadequate nutrition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person failed to ensure people using the service and others were protected against the risks associated with unsafe or unsuitable premises.
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff This was a breach of Regulation 23 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to have suitable arrangements in place to ensure staff received suitable training, supervisions and appraisals.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have suitable arrangements in place for obtaining consent from people who used the service in relation to their care and treatment
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Action we have told the provider to take

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person did not maintain accurate records in respect of people and the management of the regulated activity

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have an effective system in place to enable them to assess and monitor the quality of services provided.

The enforcement action we took:
We have served a warning notice on the provider with a timescale for compliance being 14 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to make suitable arrangements to ensure people were enabled to make or participate in making decisions relating to their care and treatment.

The enforcement action we took:
We have served a warning notice on the provider with a timescale for compliance being 14 April 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Enforcement actions

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person failed to ensure that at all times there were sufficient numbers of suitably qualified skilled and experienced staff employed and available to carry on the regulated activity.

The enforcement action we took:

We have served a warning notice on the provider with a timescale for compliance being 14 April 2015.