Real Life Options

Real Life Options - Stacey Drive

Inspection report

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Ratings

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

Overall summary

This inspection took place on 4 and 5 August 2015. The inspection was unannounced.

Stacey Drive is three, interconnected bungalows, where care and support is provided to up to 12 people who have learning disabilities and/or mental health needs and who need support to live in the community. There were ten people living in the home at the time of the inspection.

We last inspected Stacey Drive in November 2014 when we found the provider had breached the Health and Social Care Act 2008 in two regulations. We found that the requirements of the Mental Capacity Act 2005 had not been met and the systems in place to assure people would receive a high quality and safe service breached the regulations. We issued two compliance actions and asked the provider to send us an action plan detailing the improvements they would make. An action plan was not

Summary of findings

received. In August 2015 we revisited the home and found that not all of the compliance actions had been met. In addition we identified other issues of concern related to safety issues.

At the time of this inspection there was no 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. The interim manager who had been working in the home, and still worked for the provider in a different capacity, returned to the home during the inspection to provide some assistance and answer some questions.

People living at Stacey Drive could not be confident that the registered provider would be able to keep them safe. This included the arrangements to make sure staff responded appropriately in the event of a fire occurring at the home and securely stored chemicals and cleaning materials to protect people from harm. A bathroom on one bungalow had not been in full working order for several months which had impacted on the dignity of people using the service. Some areas of the home were not sufficiently clean putting people at risk from inadequate infection control measures.

There was not enough staff to accompany people to go out from the home or to undertake activities in the local or wider community, and this restricted people's choices. Agency staff were being used to cover staffing vacancies and on some night shifts there had been no permanent staff, who knew people well, working in the home.

New staff had not all been provided with an induction that would ensure they knew how to care for people and would ensure they could work safely. Staff had not all been provided with all of the training they required or with regular supervision and were not consistently following the instructions in people's care plans which placed some people at risk. .

People told us, or indicated by gestures, that they were happy at this home. They provided examples of when in the past they had been to places of interest or been supported to do things they enjoyed. We observed some caring and compassionate practice, and staff we spoke with demonstrated a positive regard for the people they were supporting. We saw staff treating people with respect and communicating well with people who did not use verbal communication.

The management of the home had recently undergone significant change. At the time of our inspection the interim manager had ceased working at the home and there was no manager, deputy manager or other senior staff working at the home. Whilst we received positive feedback from staff about the interim manager who had recently left, it was not evident that arrangements for checking the safety and quality of the service by the registered provider were effective.

We found the provider was in breach of Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

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

For adult social care services the maximum time for being in special measures will usually be no more than 12

Summary of findings

months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

People were not safe.

People were not safely protected from known risks related to their care and support needs, included assistance at mealtimes. Some aspects of medicines management needed improvement.

People who used the service were placed at risk because the provider did not have safe systems in place to reduce the risks from fire and un-secured cleaning materials. People were not safely protected by appropriate deployment and adequate staffing levels to meet their needs.

People were at risk of infection due to poor arrangements for ensuring that the home was clean.

Is the service effective?

Requires improvement

The service was not effective.

Not all staff had received training in topics that were relevant to ensure they safely met the needs of people using the service. Staff were not effectively supported or supervised.

People could not be certain their rights in line with the Mental Capacity Act

2005 would be identified and upheld.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff demonstrated that they respected people's privacy but the lack of bathing facilities in one of the bungalows impacted on people's privacy and dignity.

People were happy with the support they received. We saw good and kind

interactions between staff and people who lived in the home.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively.

Arrangements for people to be able to participate in activities they enjoyed in the community needed to be improved.

Summary of findings

The provider did not convey an openness to receiving complaints and there was a risk that people and relatives would not know how to make a formal complaint.

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager at the home.

The lack of effective management to ensure that people received the care and support they placed people at risk of harm.

The systems in place to check on the quality and safety of the service were not effective, and had not identified actions needed to improve the service provided. The provider had not ensured that people were benefitting from a service that continually met their known needs.

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Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 August 2015 and was unannounced. The inspection team comprised of two inspectors.

Before the inspection we looked at the information we already had about this provider. We looked at information received from the local authority and the statutory notifications the provider had sent to us. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During the inspection we met with all of the people who lived at the home and the relative of one person. Some people's needs meant they were unable to verbally tell us how they found living at Stacey Drive, and we observed how staff supported people throughout the inspection. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with the deputy head of operations, two agency staff, one relief staff and seven care staff. Two of the staff we spoke with were covering the night shift. We also spoke with the interim manager. The interim manager told us they had ceased to work at the home on the previous Friday and were only visiting the home briefly to assist with access to cheques and to assist with the staff rota. We looked at the care records of three people, the medicine management processes and at records maintained by the home about staffing, training and the quality of the service.

Following our inspection we spoke with the relatives of three people. The registered provider sent us further information which we had requested and this was used to support our judgment.

Inadequate

Is the service safe?

Our findings

We last inspected this service in November 2014. We found that people were not always being kept safe and we assessed the provider as "requires improvement" in this area. At our inspection in August 2015 we found that some of these concerns had not been satisfactorily addressed. The issues of concern found related to a range of issues including management of safeguarding, staffing levels on duty, skill mix of staff employed and failure to meet the known support needs of some to keep them safe.

At the time of our inspection there were some safeguarding incidents that were still under investigation by the local authority. As part of the safeguarding process the interim manager, prior to leaving, had informed the local authority that she would be arranging for one person to go to the GP for a medication review and would be arranging to have a staff meeting to discuss staff response to people being in pain or having symptoms of concern such as unexplained and untreated swellings or sore areas. We were not provided with satisfactory evidence to demonstrate this had been actioned. Shortly before our inspection visit took place we had been informed by the local authority of a safeguarding incident being reported by the provider. They told us they had discussed the concerns with the interim manager, at the time, but their responses had indicated a lack of insight into the correct safeguarding procedures that should be followed.

Safeguarding procedures were available in the home and staff we spoke with knew to report any allegation or suspicion of abuse. Staff told us that in the absence of any manager at the home they would report concerns using the on-call system. However, some staff told us they were not aware of who they should raise safeguarding concerns with, if they were not satisfied with the action taken by senior managers. We explored staff knowledge in relation to unexplained bruises or evidence of injury, and we found that whilst most of the staff we spoke with told us they would be concerned about large bruising few demonstrated awareness that any bruising could be indicative of the need to report concerns.

The provider had a whistle-blowing hotline that staff could use to report any concerns to. We noted there was no information on display in the home regarding this. A member of staff we spoke to told us they did not know if the provider had a whistle-blowing hotline. We raised this with the deputy head of operations after the inspection who told us that all staff had received information on this in their recent wage slips, no staff member had mentioned seeing such information in response to our questions.

We were not assured that risks to people's safety was being well managed. We saw that cupboards containing cleaning materials were not kept locked. We brought this to the attention of the deputy head of operations. On the second day of our visit we saw occasions when the cupboards were again unlocked. We did not see any people who lived at the home attempting to gain access to the cupboards but we did see some people walking past the cupboards so there was the potential for people to access these. The cupboards contained cleaning liquids and substances that would be harmful if ingested or in contact with eyes or skin.

We saw that in one of the bungalows there was a torn area of floor covering that was a potential trip hazard. Staff told us it had been like this for some time and they did not know when it would be repaired. The area had no tape applied to cover the tear or any other preventative measure taken that may have reduced the risk to people. This was still the case on the day of our second visit to the home.

One person had been assessed by health professionals as being at risk of choking. They had been told not to eat certain foods and this was reflected in the records available in the home. During our visit we saw staff serving the person two types of food that were recorded as being a risk to the person. We raised this with the staff concerned who told us that they had realised that the person should not have had one of the foods and had attempted to remove the ingredient "Fish it out" of the meal after it been served. We asked about the other type of food that had been given and the member of staff told us they were unsure if the person could or could not have this. The lack of clear records in the persons care plan about what foods were to be avoided did not give us assurance that all staff were fully aware of foods that were a potential choking risk

We spoke with care staff about the procedures they needed to follow in the event of the fire alarms sounding. The majority of care staff were not confident in the procedures they needed to follow. Some staff said they did not know if they should ring the on-call person before contacting the fire brigade, some staff did not know where the assembly point was. One agency staff told us if the alarm sounded they would not know what to do. Some staff told us that they had not received instruction about the home's fire

procedures. This was of concern as it could impact upon the safe evacuation of people from the premises. The fire procedure made reference to alerting the 'sleep- in' staff at night but the home no longer had a 'sleep-in' member of staff. This showed the fire procedures were not current. We looked at the records for testing the fire alarms. Care staff told us this should be done weekly but the record did not show this had been checked from May 2015 onwards. We brought this to the attention of the shift leader who told us they would ensure the alarms were tested the following day. Following our visit to the home we shared our concerns about fire safety arrangements with the fire service. They later visited the home and expressed some confidence that when they visited the deputy head of operations was on site during their visit who provided some assurance that measures would be taken to improve fire safety arrangements.

People were not provided with a clean and safe environment to live in because staff did not take

appropriate action. Relatives comments regarding the environment included; "It is generally clean, but [Person's name] bedroom is dirty"; "It's reasonably clean, but could be better". There were no dedicated housekeeping staff and care staff were responsible for undertaking cleaning of the home. We were informed that most of the cleaning tasks were undertaken by night staff who had a schedule of tasks to complete. We saw that one of the kitchens had cupboards where crumbs and debris had collected. The oven and fridge was dirty. We asked both day and night staff who was responsible for cleaning the oven and both said it was not their responsibility. We saw that one toilet was very dirty. We checked this again two hours later and saw this was still the case. Several drawer fronts and cupboards in kitchens were missing or damaged making it difficult to keep these areas suitably clean. This had been the case at our last inspection. During our inspection we were informed that a handyman had been booked to make repairs to the kitchen cupboards.

Whilst we saw that sufficient supplies of personal protective equipment such as gloves and aprons were available for staff to use and these were used by care staff during our visit staff said this was not always the case. Two members of staff told us that often supplies of these had run out which meant that staff had to provide personal care without effective means to manage the control of infection.

We asked staff if the home had an infection control lead amongst the staff team and if so, who this was. None of the care staff we spoke with were aware of the home having a nominated lead person for this area.

Failing to provide safe care and treatment is a breach of the Health and Social Care Act 2008(Regulated Activities) 2014. Regulation 12.

People who were able to communicate with us confirmed that they did feel safe living in the home. We asked if there was anything at the home that frightened people and they said no. Other people looked relaxed in the company of staff.

All the relatives we spoke with told us they felt their relatives were safe. They told us that they would be confident speaking to a member of staff if they had any concerns. Relatives said there seemed be enough staff on duty, however some of their comments included, "I feel there is too many agency staff, they don't know [name of relative] and it's not good for [name of relative]". One relative we spoke with told us, "If I could change anything, it would be more permanent staff so they could get to know [Person's name] better and meet all their needs"

Several staff told us that an extra staff was needed in one of the bungalows due to people's needs and one person needing two to one support when they were walking or needed personal care. They told us an extra member of staff was not always on shift. Staff told us that one person often tried to walk without their walking frame and was at risk of falling. They told us it was sometimes difficult to be available to monitor the person. Several staff told us that staffing levels impacted on people being able to go out into the community as they needed staff support to do this. On one of the days of our visit a person was attending a hospital appointment. An extra member of staff was on duty to facilitate this. We found that on the days of our visit there were enough staff to cover people's basic needs but found the way staff were deployed meant that they were not always available to support people to follow individual pursuits or interests. One relative told us that people did not get to go out enough because there were not enough staff.

The majority of staff we spoke with raised some concerns about the staffing levels in the home but told us staffing levels were usually safe and that the use of agency staff had reduced. .

Inadequate

Is the service safe?

Our discussions with staff indicated that agency staff were often used to cover the night shift and that sometimes there were two agency staff on duty together without a permanent member of staff. They told us that agency staff were usually used who had worked previously at the home. Following our inspection we asked the provider how they ensured the agency staff on duty were competent, qualified and had sufficient knowledge of the people in their care. We were not supplied with this information and no assurance was given that the provider had systems in place to make sure the agency staff on duty were competent, qualified and had sufficient knowledge of the people in their care. After the visit we were informed by the provider that in future, if agency staff were needed at night time there would also be a permanent member of staff on duty to ensure safety and consistency of care and support.

The interim manager told us they thought the home needed additional staff. We asked the deputy head of operations if a dependency and staffing assessment had been completed by the provider to determine the staffing levels needed in the home. We were told this had not been completed as they had based the assessment of staffing hours on the assessment provided by the local authority.

We looked at the staff rota and this showed that during the week of our visit there was no manager or senior staff working at the home. The rota indicated that for each shift there was a shift leader. Some staff we spoke with did not know who the shift leader was. Staff told us that all staff took turns in being a shift leader. This included staff who had not completed a formal induction to the home. On the day of our visit the nominated shift leader was out for several hours with a person who had to attend an appointment. An alternative staff member had not been appointed as shift leader.

Failing to provide and deploy staff in suitable numbers and with suitable skills and experience is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18.

Recently employed staff we spoke with confirmed that the necessary checks including references and a Disclosure and Barring Service check had been made before they started working in the home.

We looked at the way medicines were stored, administered and recorded. Care staff told us that medicines were only administered by staff who were trained and been assessed as competent to do so. There were suitable facilities for storing medicines. A relative we spoke with told us, “Staff do have difficulty giving [Person’s name] their medication, but they eventually get their medication with gentle coaxing”.

We observed medication being given and saw that staff checked the medication records before administering any medication. Most medication was in blister packs. On one occasion staff mistakenly popped medication from the wrong blister and immediately realised their error so there was no harm to the person. However, the staff administering medication were unclear as to the procedure they needed to follow in relation to the storage or disposal of the medication that had to be discarded, there was no on-site support available to guide them.

The records of the administration of medicines were completed by staff to show that all prescribed doses had been given to people. We saw that medicines were administered by two members of staff. People received the medicines which had been prescribed for them in the correct doses. For some people there was a photograph of them adjacent to their medication record to help reduce the risk of medication being given to the wrong person. Staff told us that photographs were available for other people but that the medication folders were in the process of being updated. They told us that they did not think this was a risk as medication was only given by care staff who knew people well.

Requires improvement

Is the service effective?

Our findings

We last inspected this service in November 2014. We found at that time that people were not receiving effective care and we assessed the provider as "requires improvement" in this area. We issued a compliance action as people could not be confident that deprivations of their liberties would be identified or appropriately referred on by staff working for the service.

At our inspection in August 2015 we found that some improvement had taken place. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. Applications had now been made to the local authority where considered appropriate by the provider. The majority of staff had received recent training in the MCA and DoLS but we found that staff had mixed levels of understanding of the MCA and DoLS. One care staff told us they had not yet had any training and did not have an understanding of the MCA and DoLS. Not all of the staff we spoke with were aware that DoLS applications had been made for people living at the home.

We saw examples of staff gaining people's consent. For example, one care staff sought a person's permission to help them take off their jumper as the care staff had observed the person looked hot. The majority of people at the home had alarms on their beds that alerted night staff to them getting up or being incontinent. People we asked were unable to tell us if they had consented to their use and care records did not show evidence of consent or decisions being made in their best interest. Staff we spoke with were not sure if best interest decisions had been made as they told us this equipment had been in use for some time. Following our inspection we were informed by the provider that best interest meetings had been held but that they were unable to locate the paperwork for these.

We looked at the induction arrangements for staff who were new to the home. We were informed by the interim manager that new staff had not had the opportunity to attend an induction but had completed a variety of training via e-learning. We were told that induction training had now been arranged for several members of staff but this was some months after they had commenced working at the home. We asked the interim manager what the induction training had covered but they told us they did not know. One member of staff who had worked at the home for a couple of months told us they had not received an induction when they started as there had been no manager at the home but did have the opportunity to work for 'shadow shifts' for one week alongside experienced staff. They told us that a formal induction had now been arranged for the week following our inspection.

We asked staff about the training they had received. They told us that much of their training had been via e-learning. The majority of staff were not positive about the value the training provided. One staff told us, "E-learning is rubbish. It is difficult to retain the knowledge and we are not provided with any booklets to refer to." Another staff told us, "It was a lot of reading, a lot to take in. I prefer something visual." The majority of staff had completed recent training on fire safety via e-learning. However we found that this had not provided staff with information about the home's fire procedures. Staff spoken with confirmed the training had included basic fire safety but had not been specific to Stacey Drive.

Some people at the home displayed difficult to manage behaviour when they became upset. One relative we spoke with told us, "Some staff need more training on how to cope with behavioural issues"; another relative told us "Occasionally some staff really need more experience and training in supporting people with complex needs". Many of the staff we spoke with confirmed they had not received this training. The training matrix did not evidence that staff had received training in managing behaviour.

We asked staff if they received regular supervision. Supervision is an important tool which helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The majority of staff we spoke with told us they had not received regular or recent supervision. One member of staff told us, "I had supervision a couple of weeks back from someone from head office. That was the first one this year."

Failing to provide staff with the training, induction and support they need to undertake their work is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 18.

Requires improvement

Is the service effective?

People who were able to communicate with us confirmed they were happy with the meals provided. One person told us, “The food is alright.” Another person confirmed they were offered choices of what they wanted to eat. Two relatives we spoke with told us there was enough to eat and drink. Another relative we spoke with said ”I wish there was more fresh food instead of all the frozen food [Person’s name] is given to eat”.

Staff told us that the menus were completed on a weekly basis and that alternatives were always available if people did not want what was on offer. We observed that during the evening meal one person did not want what was on the menu and they had an alternative which they helped to cook. We asked staff about one person who required their food to be fortified. Care staff we spoke with were aware of this and able to tell us about how the person’s needs were met.

We undertook observations of lunch and evening meals in all three bungalows. We observed some good practice from staff and for most people the meal was pleasurable event. People seemed to enjoy their meals and were allowed time to eat at their own pace. However at lunchtime in one of the bungalows people were not given choice of where they preferred to eat and there was a limited choice of food for people to choose from. One person wanted salad cream on their meal but this was not available and so mayonnaise was offered. We were told the food shopping had not been done on the usual day. This was done on the second day of our visit.

We found evidence that people had been supported to attend a range of health related appointments in relation to their routine and specialist needs. Relatives we spoke with told us, “The home ring me if there is a problem with [Person’s name] health, or even with a doctor has been called in”; another person said “[Person’s name] has recently experienced a health issue and I was informed straight away.” However for two people we were not provided with evidence to show that medication reviews had been arranged when requested by other professionals.

Some people’s care plans recorded that they needed to be weighed monthly to help ensure they were at a healthy weight. For some people this was not being done. Staff told us these people needed to use sit-on scales and the home’s sit-on scales were broken. They told us they were trying to make alternative arrangements to weigh people. They had not used any alternative methods to determine if the people had moved outside their healthy weight range.

One person at the home had a specific long term health condition that may require emergency treatment from health professionals. The staff we spoke with were aware of the person’s condition, potential triggers or indicators that the person was unwell and what they needed to do should the person be unwell. Care records showed a recent event when the person had been unwell and the emergency ambulance was called in line with their care plan.

Requires improvement

Is the service caring?

Our findings

People who were able to communicate with us confirmed that staff were caring. One person told us, "The staff are nice" another person told us, "The staff are all nice to me." One person gave an example of staff looking after their wellbeing. They told us, "When it is sunny the staff always make sure I have cream on so I don't burn." A relative we spoke with told us "Staff seem to interact well with [name of relative]";"Staff are kind, I have a good relationship with them". Relatives told us they could visit people without restrictions, comments included: "I can visit [name of relative] any time or day".

We saw staff communicating well with people. Some people were able to talk to staff and explain what they wanted and how they felt. Others needed staff to interpret gestures or understand the person's own methods of communication. We saw that staff were be able to communicate with people. People's plans contained person centred guidance for staff about how to communicate. During our visit we observed one of the staff assisting people to choose what they wanted to eat and drink by showing them what was on offer. People were then able to point to what they wanted.

Opportunities were available for people to take part in everyday living skills. People were involved in food shopping and obtaining money from the bank. One relative we spoke with told us, " [Person's name] bedroom is lovely and the staff encourage him to keep his own room tidy." During our visit we saw examples of people making themselves a drink and undertaking household chores such as sweeping up with the assistance of staff.

A relative commented that a person was often not wearing their glasses when they visited. One person's care plan recorded that they needed to wear their glasses during the day. They had not been wearing their glasses on our arrival. We later observed the person playing cards with staff but they were having to hold the cards very close to their face so they could see them. We asked staff why the person was not wearing their glasses. We were informed they had been offered that morning and the person declined. Care staff then fetched the person's glasses and assisted them to put them on so they could see the playing cards.

People made some choices about what they wanted to do and where they wanted to be. We saw people walking round between the bungalows to visit other people who lived in the home. People ate meals at different times according to choice. One person gave us an example of a recent choice they had made for themselves, they told us "I chose the frock I am wearing." However we saw examples of some people not offered choices, for example where they wanted to have their lunch. Staff advised that people were put into nightwear before the night staff came on duty, "As it was easier for the staff" Whilst we were concerned that this routine had become established and was in place for ease of staff people who were able to communicate verbally also told us that they were happy to have their night wear on in the early evening. They did not indicate that they had requested to be supported n this way.

We asked care staff what they did to protect people's dignity and privacy and all the staff we spoke with were able to describe how they did this. We saw examples of this including staff knocking on people's bedroom doors and seeking permission to enter, and doors to people's bedroom and bathrooms were kept closed when people were being supported with their personal care needs. One person's skirt was rucked up and was compromising their dignity. Staff were alert to this and immediately assisted the person to protect their dignity in a discreet manner.

An assisted bath in one of the bungalows was not working. As this was the only bathing facility in that bungalow, people had to go through adjoining doors into other bungalows to get a bath or shower. We found out that the bath had been out of use for several months. One care staff told us, "It's not right that people are having to go into other bungalows, it should be separate. You would not go to your neighbours for a shower or a bath." Staff told us that there had been some visits from engineers to look at the bath but they had not been able to repair it. Staff were not aware of any further action being taken to address this issue.

Requires improvement

Is the service responsive?

Our findings

We last inspected this service in November 2014. We assessed the provider as "requiring improvement" in this area. This inspection found that improvements were still required.

Each person had a care plan to tell staff about their needs and how any risks should be managed. Many of the care plans we looked at were not dated and so it was difficult to confirm that these were up to date. A relative we spoke with told us, "I am involved in care planning meetings for [name of relative]"; two other relatives we spoke with told us they were involved. One relative said "I was involved in care planning meetings, but it was a long time ago".

Plans contained details of the choices which people had made in relation to their lifestyle and details of their needs based on their culture and religion. For two people we noted that their care plan did not contain a risk assessment regarding the support they needed with moving and handling. Another person had bed rails fitted to their bed but there was no assessment in place regarding their use. This meant that staff may not have sufficient information about people's assessed needs to help keep them safe.

We looked at the opportunities people had to undertake interesting activities each day. People who were able to communicate with us told us they did things they enjoyed. One person told us they had been out for a coffee that day and had enjoyed going on the bus. Another person told us they had been to the pub for lunch and had a nice time. On one of the days of our visit some people had enjoyed having feet massages and nail care from a visiting therapist. Other people enjoyed time playing cards or board games with staff.

One person could not communicate their views with us so we looked at their daily records for a four week period. There was only one entry recording an activity in the community despite their care records indicated they enjoy activities such as going to the shops, swimming and going out for meals. Staff told us this person needed two staff when they went out and so there were often not enough staff to enable them to go out. They told us, "[Person's name] can usually go out on Wednesdays when the others are at college and the day centre so there are enough staff."

Relatives we spoke with told us that there used to be a variety of activities offered to their relatives, comments included, "There used to be a mini bus to take people out; but this has gone. Not so much going on now and holidays never happen. "One relative told us, "Staff take [Person's name] out for pub lunches and shopping when they can". One person told us, "We used to have a van, they took it back but I would like a van." We asked two members of staff if people had been offered the opportunity to have a holiday this year. They told us that some people would love to go on holiday but thought there would be an issue re staffing. They also told us they would not know how to go about arranging a holiday for someone.

No formal complaints had been recorded in the home's complaint log since our last inspection. People told us that they could go to the manager or staff if they wanted to complain about anything. One person told us, "I would tell the staff if I was not happy."

Comments from relatives we spoke with included: "I don't know the complaints procedure, but I would just approach the staff"; "I'm not aware of the complaints procedure, I wouldn't know who to complain to"; "Yes, I know who to complain to." One care staff we spoke with told us they did not know what the complaints procedure was.

We noted the complaints procedure was not on display in the home. People who lived at the home had been provided with an easy to read version of the complaints procedure, however this was kept within their care files in the office so was not accessible to them unless they were supported by staff. The provider did not convey openness to receiving complaints and there was a risk that people and relatives would not know how to make a formal complaint.

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Our findings

We last inspected this service in November 2014. We found that people were not benefitting from a well led service and we assessed the provider as "requires improvement" in this area. Breaches of the Health and Social Care 2008 were identified at this visit. The provider was asked to submit an action plan but did not do this. The interim manager and the deputy head of operations were not aware of any action plans being submitted to us. Our inspection in August 2015 found that the provider had not made the improvements required.

Our inspection found that the leadership, management and governance of the home had been ineffective. The registered provider had not provided the required additional support, resources or monitoring to ensure the service which had previously been rated overall as "requires improvement" improved. We did not find that a good quality service was being provided.

The deputy head of operations told us she had not seen our last report for the home as she had only been in post since June 2015. Our discussions indicated she had not been aware the home had received an inspection under our new rating system. Where a service has been awarded a rating, the provider is required under the regulations to display the rating to ensure transparency so that people and their relatives are aware. When we visited there was no rating poster on display in the home. Staff we spoke with were not aware of the rating of the home and could not recall seeing the previous inspection report for the home. Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC) of important events that happen in the home. The registered provider had not always informed us of significant events that they were required to. This did not demonstrate an open culture by the provider.

People's relatives were not complimentary about the management arrangements. A relative we spoke with told us, "I don't know who the manager is, there seems to be a lot of change" Another relative told us, "Managers cannot manage if they are not here." One relative commented, "I have been open to approach the manager in the past, I'm not sure who the manager is now."

At the time of our inspection the home did not have a manager in post and the senior support worker was on long term sick. This meant that apart from the shift leader there was no one in day to day charge of the home. We were informed that the interim manager had ceased to manage the home the week before our inspection. The deputy head of operations visited the home briefly on the first day of our inspection. They told us it was planned that an agency manager would commence in the home the following week as a previously recruited manager had changed their mind about working at the home at short notice. Meantime they told us that senior managers would be visiting the home daily. On the second day of our visit we noted that no senior manager visited the home either before or during our visit. Following our inspection we were informed by the provider that a new manager had been identified and would be starting once their DBS check had been returned. They advised that in the interim a manager from another service would be managing the home.

Staff told us that the interim manager had been approachable. One member of staff told us, "She has built the home up, she is very approachable. It was all in a mess when she started." Another staff member told us that the home had a lot of managers in a short space of time. They told us the most recent interim manager had been good but that she had too many homes to manage. Our discussions with the former interim manager (who continued to work for the provider in a different capacity) indicated that in addition to managing Stacey Drive she had also managed another service and worked at a third service. She told us she had usually been able to designate two to three hours most days to working at Stacey Drive but that she had now stopped being the interim manager.

Staff had mixed views about the support they received. One member of staff told us that whilst there was no manager or senior in post there was always someone on call who they could contact for advice. One staff told us, "I feel supported but if you need to ask something I am not always sure who to ask." Another staff told us, "Staff have been running the home with no support. Senior managers have not rung us to ask how we are and what support we need. The onus has been on us to ring." One care staff told us that staff morale was low as there was no stability regarding the management arrangements in the home.

Although there were some systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against key risks in relation to

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inappropriate or unsafe care and support and management of risks. The provider had undertaken an audit in May and June 2015 to focus on the key question, 'Is the service safe?'. We found that some of the issues they had identified remained the same despite an action plan being produced. The providers audit had not identified all of the concerns we found regarding fire safety arrangements.

We asked care staff about the procedures for reporting accidents and incidents. They told us that when these occurred they completed a form and usually left this on the manager's desk. A folder was available in the home for incident reporting but we found there were no records for 2015.

We asked the provider to send us evidence of how incidents are recorded and monitored and any evidence that accidents, incidents and safeguarding concerns are analysed to identify any patterns or trends. The provider responded that they were unable to locate the incident forms in the home. They informed us that the policy was these to be sent to the Divisional Manager for signing along with accident analysis and that a request to see if these are with him at this time had been sent. It was a concern that the provider was not able to provide us with the information we requested.

There was no evidence to indicate that the provider had acted on feedback to mitigate risks identified. During inspection activity and from monitoring visits very similar concerns about issues, had been raised (the previous CQC inspection in November 2014, the monitoring visit by the Local Authority in July 2015 and on the most recent inspection in August 2015 by CQC). Despite these prompts no satisfactory action had been taken to address the risks. The issues included safe storage of COSHH items, inconsistent or inadequate health and safety checks and recording of significant events.

These issues regarding governance and oversight of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

We looked at the systems in place to safeguard people's money. Staff told us that they counted and checked people's monies at every shift changeover to make sure it was correct. We saw staff doing this during our visit. The deputy head of operations told us she had recently completed an audit of people's monies. She told us this had resulted in some reimbursements of monies to people where they had been paying for meals out. This demonstrated the audit had resulted in improvements in the way people's monies were being used.

Comments from people's relatives did not evidence that their views on the quality of the service had been sought. Comments from relatives we spoke with included, "I have completed a satisfaction survey, but it was a very long time ago"; and, "I've never completed any satisfaction surveys".

Some people at the home used wheelchairs and a member of staff told us that one person could not go out as their wheelchair was broken. Records were not available to show that checks or servicing of wheelchairs had been undertaken. Following our inspection the provider told us that the person's wheelchair was not broken. They told us that wheelchairs were checked by staff but this was not documented unless an issue was notified. We were informed this now formed part of the weekly health and safety check list that had been implemented.

Minutes of staff meetings indicated there had been no meetings in 2015.We were informed by both the former interim manager and members of staff that there had been recent staff meeting. However records of this meeting were not available in the home and could not be provided by the provider when we requested these. This meant that there was no record available of what was discussed and that staff who could not attend the meeting may not have been fully aware of any discussions held. Following our visit we were made aware by the provider that a meeting with staff had been scheduled for a few days after our visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Failing to provide safe care and treatment is a breach of the regulations. People who use the service were not protected against the risks associated with inadequate measures to assess risks or take action to mitigate such risks. (12(2) (a) (b))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were at risk of not having their needs met due to failure of the registered provider to provide and deploy staff in suitable numbers and with suitable skills and experience. (18 (1) (2))

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The absence of effective systems and processes to ensure that the provider could ensure that compliance with the regulations could be achieved failed to ensure that health, safety and welfare of people using the services was assured. (17(1) (2)(a) (b) (d) (e) and (f))

The enforcement action we took:
We have issued a warning notice to be met by 6 November 2015.