Henshaws Society for Blind People

Henshaws Society for Blind People - 45 Yew Tree Lane

Inspection report

45 Yew Tree Lane
Northern Moor
Manchester
Greater Manchester
M23 0DU

Tel: 01619453665
Website: www.henshaws.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on 13 and 14 September 2016. The first day was unannounced, which meant the service did not know we were coming. The second day was by arrangement.

The previous inspection took place on 10 September 2014. At that inspection we found the service was meeting the regulations we looked at.

Henshaws Society for Blind People (Henshaws) runs a home for up to six people at 45 Yew Tree Lane, in Northern Moor in south Manchester. There were five people living in the home at the date of the inspection. The people living there were young men who mostly had a visual impairment, and also had other complex care needs. They each had a bedroom, and shared a communal living area and dining area.

At the date of this inspection the registered manager was just about to leave, after six years in post. There was a process ongoing to appoint a new registered manager. 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 found an allegation of abuse which had been investigated internally but had not been reported as a safeguarding incident.

We found the home was a safe environment for people with visual impairment, three of whom could walk around the house freely. We pointed out a couple of trip hazards.

At the time of this inspection there was someone living in the home on a temporary basis with a view to a permanent placement. His needs and abilities were different from those of the other people in the home. The behaviour that partly resulted from the inability to meet this person's needs at the service had caused the others to become inhibited about moving around.

Staffing levels were appropriate to meet the basic care needs of people living at the home however at times more staff were needed to support people with their planned activities. One person required one to one support which meant there were fewer staff available for activities with the others. When there was one fewer staff working, as happened on the first morning of our inspection, activities had to be cancelled.

There had been no staff recruited from outside Henshaws for three years. This created the benefit of continuity but also the risk of staff being too comfortable in their routines.

Medicines were ordered, stored, administered and recorded in safe ways. However we found improvements were needed because the instructions for PRN or 'as required' medicines needed to be clearer, and the cabinet for controlled drugs needed to be made secure.

Fire precautions were in place and equipment was serviced. There were individual plans for evacuation, but the person who had arrived in July 2016 did not yet have one in place.

We were told that training took place but there was no record of training available, so the provider was unable to demonstrate that all staff training was up to date. We requested the training record be forwarded to us after the inspection but did not receive it. This was a breach of the regulation regarding training of staff. There were some records of supervision but not of annual appraisals.

The service was applying the Mental Capacity Act 2005 (MCA) and had carried out mental capacity assessments on all the people living in the home. Applications under the Deprivation of Liberty Safeguards (DoLS) had recently been made for four people, but not for one person on respite, although he had been in the home for two months. This was a breach of the regulation relating to protecting people from an unlawful deprivation of liberty.

Food was cooked by staff. We did not see people involved in helping to prepare meals. The menus were similar from one week to the next. People's diets were monitored.

The service ensured that people were registered with a GP and kept appointments with medical professionals.

The view of families and professionals was that the home was a very caring environment. Staff were most often kind to the people they were supporting. People were encouraged to be independent, although that had been affected by the current situation in the home.

People received appropriate help with their personal care. People got up quite late in the mornings, but this was their choice (except for one person). Those who could took part in chores around the home.

Confidentiality of people's personal information was respected.

Care records were very detailed to the extent that it was difficult to find specific information in them. There was some obsolete information. We found little evidence that people had been involved in the writing or review of their own care plans.

One person was not receiving much attention or stimulation even though he was receiving one to one support. He spent a long time in bed in the morning and also in the afternoon. Staff appeared uncertain how to respond to or help him manage any behaviours that challenged staff and others. This was a breach of the regulation relating to meeting people's needs. We considered that the impact on others in the home represented a breach of the regulation relating to respect and dignity.

Activities did take place although on the day of our visit they were cancelled due to staff sickness. Some people engaged in a variety of activities each week, others less so. There had been a holiday in September 2015 and another one was being planned. One family member expressed the view there were fewer activities than they expected. This was a further breach of the regulation relating to meeting people's needs.

There was a complaints policy and log. A recent complaint had not been recorded, but had received a detailed response.

The registered manager of the service was about to leave and be replaced. The staff were nearly all long – serving and offered consistency of care.

The aim of the provider organisation was to enable people with visual or other disabilities to exceed expectations. We found this was the aim of the service, but that there were times when people were sitting listening to the TV with no purposeful activity.

The registered manager told us that lessons had recently been learned about a poor pre-admission assessment process. However, the decision had impacted on the quality of life in the home. Along with examples of poor records, this was a breach of the regulation relating to good governance.

There was a range of audits carried out. Reviews and audits of care plans needed to be more thorough and address the content of the care plans. Staff from the provider visited to carry out assessments.

Staff meetings took place. The minutes suggested that these were used as a means of reminding staff of their duties and obligations. It was less clear they were an opportunity for staff to raise issues themselves.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

An allegation made by someone living in the home had not been reported as a safeguarding incident. The home was a safe space, but people's confidence to walk around safely had been impacted by the provider's decision to support a person with different needs to those people living at the service.

The availability of staff was reduced when one member of staff was ill and was not replaced. There had been no recent recruitment.

Medicines were handled safely and there were adequate fire precautions.

Is the service effective?

Requires Improvement

The service was not always effective.

There was no record of training available. Staff told us about receiving training they had received.

The service was following the principles of the Mental Capacity Act 2005 and had applied for Deprivation of Liberty Safeguards authorisations for people who lived at the service but not for one person who was residing there temporarily.

Food was cooked and eaten together, and people's diet and weight were monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not respected at all times.

Our observation was that staff were kind and considerate, and this was confirmed by the comments of professionals and families.

Help was given with personal care according to need.

People were encouraged to be independent, so far as they could, by helping with tasks around the home, although they could be encouraged to help more in the kitchen.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were thorough but too bulky. People's needs were being met with one exception, where staff were unsure how they could best respond.

There were activities arranged, although there was scope for new activities to be introduced.

A recent complaint had been responded to but not recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service was going through a change of registered manager. A poorly managed pre-admission assessment had affected the quality of the service and staff morale.

Audits took place and lessons were learned from mistakes. Staff meetings were used mainly to remind staff of their obligations rather than allowing staff to contribute ideas.

Henshaws Society for Blind People - 45 Yew Tree Lane

Detailed findings

Background to this inspection

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

The inspection took place on 13 and 14 September 2016. We did not give advance notice of our arrival on the first day. The inspection team on the first day was an adult social care Inspector, and a specialist advisor, who had expertise in working with young people with sensory disabilities. On the second day the Inspector returned to complete the inspection and give feedback.

Before the inspection we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR along with other information we held about the service, including notifications received from the service and information from other sources.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. They had not made any recent visits.

We talked with and observed the five people using the service, and talked with one visiting relative, five members of staff and the registered manager and deputy manager, and a district nurse. We also talked by telephone with two relatives of people living in the home, and received emails from them.

We looked at four care records, two medicine administration records, five staff files, and staff rotas, staff meeting notes and other information. We requested some information be sent to us, namely training records, which however we did not receive.

Requires Improvement

Is the service safe?

Our findings

We looked at how safeguarding issues were identified and reported. Staff had attended training on safeguarding although we did not receive the overall training record to confirm that all staff were up to date with training. When we spoke with staff they knew what types of abuse to look out for and how to report it. In the two years since the previous inspection Henshaws had not reported any safeguarding incidents to us, until three in close succession in the few weeks before the inspection. These issues had been correctly identified and reported, and had either been dealt with or were being dealt with by the service.

While looking as staff records, we found reference to an allegation of abuse which had been made by one person living in the home against one member of staff. We enquired about this, and were told that the allegation had been investigated and found to be untrue. We discussed with the registered manager and the deputy manager the requirement to report all allegations of abuse. We knew from recent referrals that the service understood the obligation to report safeguarding incidents.

Four of the five young men living in the house were either blind or had severe visual impairment. Three of these people had lived in the home a long time, and were independently mobile. They were able to walk around safely because they knew the layout of the furniture and the rooms. The house was not purpose built but was well designed for the needs of people with visual impairment. Downstairs the communal area was open plan, with a large table in the dining area, and comfortable sofas in the living room. We saw that by walking carefully, and where necessary using their hands to guide them, people could move around independently and safely.

We noticed two potential trip hazards which we brought to the attention of the registered manager. New carpets were being installed in some of the bedrooms and corridors during our visit. One of the edges of the carpet at the doorway to a bedroom was slightly raised, which was a potential risk to a visually impaired person. We mentioned this to the registered manager who said she would ensure that all the new carpets and fittings were checked for safety.

The patio door from the living room opened into the garden. The weather was pleasant and warm on the first day of our inspection and a member of staff opened the door for fresh air. They placed a wire gate, about a metre high, in the doorway to stop the pet rabbit getting inside. One of the people living in the home told us that the rabbit had a habit of chewing through cables. We considered that the wire gate was a trip hazard especially for people with limited or no vision, who might easily try to walk outside into the garden. We were assured that no accidents had occurred during the summer, and if people were going in and out all the time the rabbit would be confined to its cage and the gate removed.

There was one issue which was affecting the confidence of people living in the home. At the time of our visit there was one person living in the home on respite since July 2016. This person's needs were different from those of the others. He had no visual impairment, and was not able to communicate verbally. He tended to grab people as they passed in order to gain their attention. This was particularly difficult for people with a visual impairment to avoid. We saw numerous reports of incidents where he had grabbed hold of various

people (including staff) causing pain and discomfort. The result was that some of the people were reluctant to walk around independently. Staff placed this person's wheelchair on one side of the living room to reduce the chances of him being able to reach people, but this did not work because of the small area of the room. We saw one person asking, "Is [name] about?" before being willing to get up from the sofa to cross the room. People would ask staff to accompany them where ordinarily they would have moved independently. One member of staff said to us, "The lads always ask about if [name] is in the room. They can't move when he's there." We also saw a report where one person had gone to their bedroom following such an incident and stayed there.

This was a situation which was affecting both people living in the home and staff. However, we acknowledged there was little more that the staff could do to help people feel safe in the communal areas. The person concerned had a right to be in the living room in the company of others. We learnt that the time he would be there was limited, and the service were not intending to extend the duration.

We asked about staffing levels. We were told and confirmed from the rota that there were normally four staff on duty in the mornings, three in the afternoons and at weekends, and two during the night, one of whom stayed awake. One person was assigned one to one care, meaning that one member of staff would stay with them constantly, when they were up and about. Staff were not sure, but the registered manager assured us that the staff numbers had been increased to provide this one to one cover. This meant the availability of staff for the other four people had not been affected by the fifth person's arrival.

On the morning we arrived one member of staff had called in sick the night before. There had been an attempt to phone other members of the staff team to see if anyone was available to work in the morning. One member of staff on the afternoon shift told us they had received such a call. But no-one had been available, which meant there were only three staff at work when we arrived. One of these was from an agency, and had worked at the home several times before. They told us they were assigned to support the person who needed one to one care. This meant that there were two staff to support the other four people. It was the registered manager's day off and the deputy manager was due in later that morning. This was not an unsafe level of staffing support, but it meant that scheduled activities could not take place.

Accidents and incidents were reported and recorded. We saw that the registered manager had written a comment on each incident. In some cases action was taken to prevent a recurrence. For example after someone had fallen in their bathroom their care plan was changed to require staff to be present whenever that person was transferring from their wheelchair. We saw from the minutes this was specifically mentioned at a staff meeting. This showed that lessons were learned from incidents and measures taken to ensure the lessons were shared with staff, in order to keep people safe.

There had been no recruitment of new staff for three years. One member of staff had moved from bank staff into a permanent position. Recruitment was carried out by the provider's staff based in another office, and the paperwork relating to new staff was stored in that office. As there had been no recent recruitment from outside the company we were unable to check whether correct recruitment practices had been followed. The deputy manager told us there were currently no bank staff, which meant that agency staff had to be used if there was staff sickness or holidays. Two agencies were used, and usually supplied regular workers who had worked at Henshaws before. Using agency staff was not ideal given the very specialised needs of the people living in the home, which meant they needed staff who knew them very well.

We looked at how medicines were obtained, stored and administered. All the staff took it in turns to administer medicines when it was their turn on the rota to be 'keyholder'. We saw this system had been reinforced by the registered manager in June 2016 when she started, "There will be one dedicated

medication giver for each day." The explanation given was, "There are issues with too many staff giving medicines out and it is hard to keep track for staff." We were told the keyholder system was working well and if for any reason the keyholder was not in work then another member of staff would become keyholder. This had happened on the first day of our inspection.

When medicines were given they were recorded on medicine administration record (MAR) sheets, and the two we looked at were fully completed without gaps. We saw on the MAR sheets brief instructions about when PRN or 'as required' medicines should be given. These are medicines which are prescribed to be given only when a person needs them. One of these was paracetamol to be given for pain relief. The instructions did not indicate what signs of pain to look for if the person could not express themselves verbally. There was also one person whose care plan stated he was allergic to nuts and strawberries, and would have a very dangerous reaction if he consumed either. The PRN medicine instructions stated that it should be given if he had ingested nuts, but did not mention strawberries. This meant there was a contradiction between the care plan and the PRN instructions. This was potentially a risk if staff did not know about the allergy, and we mentioned the risk to the registered manager. She stated that all the regular staff knew about the allergy, and agency staff would not be involved in administering the medicine.

Medicines were ordered from a local pharmacy. We were told there were never any problems with the supply of medicines. This was confirmed by a district nurse who regularly visited one of the people living in the home. They said that the medicines needed were always available in the home. Medicines were stored in a locked cupboard. At a previous inspection we had instructed that a special lockable cabinet was needed to store controlled drugs. These are drugs which by their nature require extra security. We saw the cabinet had been purchased and was in use, inside the cupboard. However, it was not fixed to a permanent wall or to the floor, as is required by the Misuse of Drugs (Safe Custody) Regulations 1973. We raised this to the registered manager and deputy manager who said they would ensure it was fixed.

We saw evidence of how people were protected against the risk of a fire. There was a fire risk assessment and a fire safety logbook which was kept up to date. Greater Manchester Fire and Rescue Service had conducted an audit in January 2016 and found the premises 'broadly compliant' with regulations. Required actions had been undertaken. The emergency lighting was tested monthly although we noticed some months had been missed recently (May, June and August 2016). The fire alarm system was also checked, and the fire extinguishers were serviced. We did not see a record of a recent fire drill.

We saw that personal emergency evacuation plans (PEEPs) had been written for each person, describing the location of their bedrooms, their mobility, visual impairment and the degree of help they would need to evacuate the building. A copy of these PEEPs was kept in a folder by the front door to enable the fire service to access it in an emergency. We saw that they were not up to date. There was a PEEP for a person who had left the service in May 2016, but not one for the person who had joined the service on respite in July 2016. In practice this did not represent a great risk, because the two people had identical mobility needs and the bedroom was the same one. However, the failure to provide an accurate PEEP was indicative of the service not keeping up to date.

We saw documents relating to routine maintenance of the building. There was a procedure to check for and avoid legionella; little used taps were opened periodically. The home was cleaned on a daily basis, and measures taken to maintain hygiene. We noted that the clinical waste bin in the driveway did not have a lock, which was a potential health hazard.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us in the Provider Information Return (PIR) that staff were up to date with what she called mandatory training, including infection control, food hygiene, medication, moving and handling and safeguarding. A staff member told us, "The company is very good and offers lots of training throughout the year and refresher courses. For example we all recently had training on PEG feeding because someone new needed it." (PEG feeding is feeding through a tube).

However, it was difficult to verify what training had been done and whether all staff had done it. Individual staff members' files contained certificates for all the training they had ever done. These needed rationalising to help identify which training was current and which needed updating. There was a cover sheet in each file but it was not reliable. For example one staff member was recorded as having attended safeguarding training in October 2014. Next to this it stated "Update due 28-10-15" but that had been crossed out, and there was no record of whether training had been undertaken. The registered manager assured us that there had been safeguarding
training in October 2015 and it was just the record which was not up to date. The deputy manager told us they had delivered practical moving and handling training to all staff in recent months.

In the PIR there is a table requesting information about how many staff had received training in key areas. This section of the PIR had not been completed. We were told that there was a training spreadsheet or matrix which recorded all staff training. We asked both the registered manager and the deputy manager to forward this to us, and reminded the deputy manager in an email immediately after the inspection, but it was not provided.

In our previous report from the inspection in September 2014 we recorded that the registered manager had made a request for autism training to be delivered, and also challenging behaviour training for working with people with learning and physical disabilities. Because of the lack of training information available to us both at the inspection visit and afterwards we saw no evidence that these courses had been delivered. We also recommended in our last report that the service should "ensure that the spreadsheet is regularly monitored and that all staff keep up to date with training courses." Following that report we received an email from the Director of Housing and Support which stated, "I will also ensure that the Training spread sheet is available on site." This had either not happened or not been maintained until the date of this inspection.

One family member had submitted a complaint in August 2016 about one staff member. They commented, "[Name] clearly needs training updating to a far higher level than [he/she] has because at this moment their level does not have a standard for a young man with [name's] needs." Although this was a single incident, it indicated that training needed a higher priority within the service, perhaps especially for longer serving staff who needed to be challenged to stay fresh and open to new ideas. In the minutes of a staff meeting in July 2016 it was recorded that "There may be some free training available for staff to complete the Care Certificate." However, the Care Certificate is designed primarily for new recruits and staff new to care, rather than established staff who would require more advanced training.

The lack of evidence and the poor recording of training meant that we could not be confident that staff were receiving the training they needed to enable them to carry out their duties. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us that staff received supervision every eight weeks. There was no overall record of when supervisions were due or had been given. Records of supervision were kept on individual staff files. We saw that one member of staff had received three supervisions in 2014 and three in 2015, which was less frequent than one every eight weeks. This person told us their supervisions were every three or four months. We did see that detailed notes were recorded and that the supervision sessions allowed staff to raise issues for discussion.

The PIR informed us that all staff had received an annual appraisal within the last 12 months. We saw no records of these. One member of staff told us they had could not remember when they had last had an appraisal. Another staff member said they had received one appraisal in the last eight years. The lack of accurate record keeping in relation to staff support and training meant the provider was unable to demonstrate to us that staff had the skills and knowledge required to support people who used the service.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Care homes can grant themselves a temporary 'urgent' authorisation but need to apply to the relevant local authority for a 'standard' authorisation.

All the people living in the home had had a mental capacity assessment. The document used by Henshaws stated that the assessment should be completed during the pre-placement assessment or no later than the first care plan. In the case of one person who had arrived on respite on 12 July 2016, their mental capacity assessment had only been completed on 11 September 2016, which did not match the required timescale. For those people who had been in the home a long time the document recorded when annual reviews were due, although we saw these had not always been done or recorded as done.

The document required the assessor to answer set questions about the person's mental capacity, in order to determine whether they had capacity to make decisions about daily living, and if the answer was "No" then to list the individual decisions that the person lacked capacity to make for themselves. This procedure emphasised, correctly, that the assessment needed to be decision specific, in other words relate to individual decisions.

We saw that staff asked for consent for everyday activities and asked people what they wanted to do. The registered manager told us that one person who was a little reluctant to exercise would consent to do so, provided a member of staff read a book to him during the exercise.

DoLS applications had been made in recent months for the four people who had resided in the home for a long time. They had all been made to different local authorities. We saw several applications had been

made on 3 June 2016. No application had yet been authorised, although they were being processed. We asked why it had taken so long for applications to be made, because there had been a Supreme Court judgment in March 2014 which emphasised the need for all care homes to consider the need to apply for DoLS authorisations. One person's application stated, "[name] is restricted from leaving the home alone" which was sufficient reason for applying for a DoLS authorisation, but had been the case for years. We were told the initiative to apply now had been made by a new senior manager within Henshaws.

More seriously, we saw that a DoLS application had not been made for one person who had arrived on respite in July 2016. He needed help with all aspects of daily living, and his bed had high sides for his own protection. His care plan stated, "I will need a bed with high cot sides otherwise I will try to climb out." Due to his complex needs it was clear that he was being subjected to a deprivation of liberty which was unlawful because it was unauthorised. The service ought to have considered this immediately upon or even before his arrival in the home, and submitted a DoLS application. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff on duty cooked hot meals during the day. The meals we saw were appetising and enjoyed. Fresh vegetables were used and there was fruit available. We were told that a takeaway on a Saturday night was everyone's favourite.

Menus for the week ahead were planned in consultation between people living in the home and staff, and a shopping list drawn up. On care files, we noticed the menu planning sheet with the week's food choices. It looked the same or very similar every week. There were many food choices that had limited nutritional value. We would have expected the menu to incorporate a greater variety and range of foods, rather than the same every week.

People's diet and their weight were monitored regularly. We knew there had been concerns at the last inspection about one person losing weight, but these had been addressed. One person was encouraged to exercise in their bedroom in order to help control their weight.

Everyone was registered with a local GP. We saw evidence of appointments with specialists, and that staff accompanied people to appointments. Everyone had a health action plan. There was a 'traffic light' pack containing essential information to be taken along if anyone needed urgent hospital admission.

Requires Improvement

Is the service caring?

Our findings

A family member had commented in a questionnaire that the quality of care was "excellent". The district nurse visiting one of the people in the home said, "[Name] is really happy. The staff always seem calm and friendly towards him." We saw that in general the staff were kind, patient and considerate with the people they were supporting in the home. With the people who had been there many years they had established friendly relationships but we saw no signs of over-familiarity. The registered manager said, "We have worked with these service users for a long time, they are like our extended family."

There was a sympathetic approach to people's disabilities. At breakfast one person said "I've spilt some cereal on the table." The member of staff kindly said "It's alright. We'll clean it up in a minute." There were exceptions to this. On one occasion we witnessed one member of staff talking rather harshly to one person, in an unkind tone, but this was only on one occasion. We raised this with the registered manager who assured us this would be addressed.

People living with autism often benefit from fixed routines. There was a comment in the minutes of a staff meeting in October 2015 suggesting that staff needed to be reminded of this: "Staff to work consistently with [name], you are causing his behaviours to escalate by doing your own thing." The comment also showed that the registered manager had acted to try to ensure a more consistent approach by staff.

To some extent the caring approach had been disrupted by the arrival of a person on respite, which had affected the atmosphere in the home and to some extent had reduced the independence of the other people. As the deputy manager commented, "The others can't be independent while he's around." We acknowledged that this was a temporary situation until an alternative placement could be found.

People received help with personal grooming and with choosing what clothes to wear. They all looked presentable and comfortable. This meant that their dignity was maintained. We observed that staff treated people's bedrooms as their private space, knocking before entering.

People were allowed to get up in their own time, unless they had an appointment to attend or an activity planned, in which case they would be woken. This meant there was a very leisurely start to the day, but also reduced the time available for activities.

People living in the home were involved to varying degrees in various tasks around the home. For example in the morning some people carried their laundry in individual baskets. Those who could were involved in tidying their rooms and helping to clean out the rabbit's cage in the garden. They were also involved in the purchasing and preparation of food. Although most of the food was ordered online, staff often asked one or other person to accompany them to the local shops.

At breakfast we saw the three people who were independently mobile were encouraged to help themselves to cereal and toast. They were also involved in clearing up afterwards. There was more limited involvement in the kitchen at lunchtime or dinnertime, although it was mentioned in some people's care plans. This was

partly because the kitchen was a small area and this posed a risk for people with visual impairment. However we considered there was scope for some people to become involved in cooking activities.

Involvement in household chores formed part of assisting individuals to be independent. We saw that staff had been reminded at a staff meeting in July 2016 of the need to maintain independence, in terms which suggested it was not always done: "The staff should be encouraging the service users to be much more independent; staff are trying to do a lot of things for the service users that they could be doing themselves, so staff should encourage them more."

At the same meeting staff were reminded of the need for confidentiality: "You should be very careful what you are discussing in front of service users." Because there was no staff room, staff tended to relax and socialise with people living in the home and other staff, especially around the dining table. We were told there was no particular incident which had prompted this reminder to staff, it was just advice from the registered manager. While we were present care records and other files were kept in lockable cupboards so that visitors would not be able to see them.

Requires Improvement

Is the service responsive?

Our findings

We looked at care files for several people and read two in detail. The files were divided into two sections, a 'personal care file' for in depth information and an 'easy access' file for daily use. The first contained personal details, and a section entitled 'All about me' which listed people's routines, likes and dislikes. The 'easy access file' contained weekly menu sheets, night record sheets, and contact details for family and professionals.

In the personal care file there were detailed risk assessments relating to all aspects of care, including mobility, allergies, and (where relevant) epilepsy plan. Mental capacity assessments and DoLS applications were stored. There was a weight chart, assessments and reviews, and relevant correspondence. For those people who had been in the home for several years or more the files were bulky and needed to be rationalised. There was outdated information, and too much information to be easily accessible for visiting professionals or for agency staff. There was little evidence of involvement by the people in the home in the creation or development of their own care plans.

We also noted that information was separated within the files and there were often no signposts to assist finding relevant sections. For example, one person's 'easy access' file stated that they had some low level swallowing difficulties. There was no link to the personal care file where there were safe eating guidelines.

Some reviews were noted on the care plan, but not all were signed and/or dated.

The service was responding not only to people's physical needs for comfort, shelter and food, but also to their emotional needs for company, stimulation and activity. We found that Henshaws had created a homely atmosphere where these needs could be met, but that there was scope for more appropriate activities to be developed.

The most significant example was in relation to the person who was there on respite. Most of the staff seemed unsure how to respond to him reaching out to grab anyone in his vicinity other than by keeping well out of reach. Even the member of staff who was providing 1:1 care and support spent most of their time observing him from a distance rather than attempting to engage. We knew from this person's care plan that he could enjoy simple games. We met a relative who told us, "[Name] loves to play games and have fun although on a very basic level. He loves to laugh and needs lots of attention and stimulation." However for long periods he was left isolated. Even in the living room at one point he was facing the wall.

The lack of appropriate assessment and treatment of this individual was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also noticed he was the last person to get up in the morning, being left in bed until 10.50am, although he was awake. This was a long time in bed and without any interactions or stimulation other than the TV to keep him occupied. The registered manager and staff told us that on some days he got up earlier. He was also put back on his bed in the afternoon. We received various explanations for why this happened: that he

needed a new wheelchair, and because of a health condition affecting his spine. We did not see any staff going into his bedroom to check on his wellbeing.

We noted that detailed behaviour guidelines had been written in the care plan: "It is important that the people working with [name] know him very well and are able to understand his keys and prompts." That being so, it was not appropriate that an agency worker who had been in the home only a few times had been assigned to provide one to one cover that day.

Both the registered manager and the deputy manager acknowledged that the service was unable to meet this person's needs, although they stressed this had not been obvious prior to his admission on respite in July 2016. We did see three weeks of activity records during August, which included various outings three days a week. The registered manager had stated in an email, "We cannot possibly do more activities with [name] without over stimulating him and over tiring him."

We considered that insufficient thought had gone into meeting this person's needs, and that he was being treated with a lack of respect. We also considered that the effect his presence was having on the other people living in the home was disrespectful towards them and was impacting on people's ability to be independent. This was a breach of Regulation 10(1) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had in the past been 'Student meetings' where people were asked their preferences about activities and all aspects of life in the home. The last of those meetings had been in August 2015, and the registered manager told us that people had not wanted to hold such meetings since then. Instead they preferred individual meetings once a week where they discussed the menus and activities for the following week. We asked one of the people living in the home about holding such meetings but they did not express a preference either way.

A member of staff told us, "We do our best to help them go out and about", but admitted this depended on staff availability, and opportunities had reduced in the last two months. Swimming had been on the activity schedule for the first morning of our inspection but was cancelled due to the sickness of one member of staff. We saw that there was a weekly activity schedule although they were similar from one week to the next.

One person was very enthusiastic about a drama class he attended weekly, and described the part he was playing. This had continued since our inspection in 2014 and was evidently something he very much enjoyed. The same person now had two keyboards, one large and small, and demonstrated various tunes. He listened to talking books, although we were not sure the books (eg the Famous Five) were age appropriate and thought he might benefit from something more stimulating. Staff told us they had tried other books with him in the past. He had a treadmill in his room. He also had gym membership. However, their relative expressed doubts about how often he was attending the gym: "I have taken out a gym membership for [name]. I am told he goes quite often, I am not sure about this. He did go often when the membership was first taken out, but the carer who initiated the visits to the gym has now left."

Other people did not have as much to occupy themselves either in or outside the home. One relative made the comment "When I visit too many times service users have just been sitting around listening to the TV…I have made suggestions for activities that [name] likes, few have been taken up." This relative also drew a comparison between this home and others run by the same provider: "I am sure they should be doing a lot more. If you compare the activities between the homes that Henshaws have in Harrogate and the one at Yew Tree Lane I am sure that there is a big difference…A lot more goes on at the homes in Harrogate which I

think is unfair."

We talked with a member of staff who stated that there could be more activities and more options available to people living in the home. The lack of sufficient activities was a further breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously the service had owned a minibus which facilitated trips out, but this had not been replaced for several years. Instead taxis were used. In previous reports we commented on the absence of an annual holiday. On this occasion we learnt three people had been on a caravan holiday in Wales in September 2015, accompanied by three members of staff. Another holiday was being planned. Staff volunteered their time to go on these holidays, but it was the provider's policy to arrange an annual holiday for people using the service.

In the PIR the registered manager stated her intention to reintroduce a communication system with families to send them regular updates about activities inside and outside the home. We knew from previous inspections that this was appreciated by families, most of whom lived in different parts of the country and so did not visit very often. However, this had not yet happened. One relative stated to us, "They used to send me a weekly timetable of what [name] had been up to, often I had to chase them up for it. To date I have not had one for a considerable time (months)."

Annual questionnaires were given to people living in the home, for them to complete as best they could, with staff assistance. Unfortunately the responses from the last questionnaire in November 2015 could not be produced.

Henshaws had a policy for dealing with complaints. This stated that all complaints would be responded to in writing or by appropriate means, and an action plan written if necessary. In the complaints file there were no recorded complaints since July 2014. However we knew at the inspection of a complaint which was being dealt with, and we then received from a relative a copy of a complaint they had submitted on 23 August 2016, together with a reply they had received dated 24 August 2016. We saw that the registered manager had responded in detail to issues raised in the complaint, but the complaint was ongoing.

Requires Improvement

Is the service well-led?

Our findings

Prior to our visit we had received notification that the registered manager was about to leave Henshaws for a new post, and that the provider was in the process of appointing a new registered manager. This transition was taking place at a difficult time for the service, as has been described in this report. Bearing that in mind, there was still a lot to be done to achieve a smooth handover to the deputy manager, who would become acting manager until the appointment of a new registered manager. The local management was supported by the Head of Housing and Support and other staff of the provider.

There were no senior care workers which meant that when both the registered manager and deputy manager were not present, it was unclear who was the responsible member of staff in the event of an issue or an emergency. This was the case on the first morning of our inspection.

The fact that the majority of staff had worked in the home for many years, and there had been no recent recruitment from outside the organisation, created both benefits and drawbacks. Staff were experienced and familiar with the people living in the home, but needed encouragement to develop new ways of working or to see where things could be done better.

Staff morale had been affected by recent events in the home. This had affected staff attendance, and there were unusually high levels of sickness absence. We noticed, however, that the absence levels were a longstanding issue. In May 2016 it was recorded that several staff were about to be put on 'Stage 1 sickness hearings', which meant that their attendance had become a cause of concern to the managers. In terms of staff morale, we saw staff meetings were used as reminders to staff and for the issuing of instructions. The minutes of meetings did not record any recognition of good practice or celebration of success. Despite this, staff told us they still enjoyed the work, in particular being with the young people.

The mission statement of Henshaws is to "support people living with sight loss and a range of other disabilities to go beyond expectations." We were told that this was the aim of the home. When the full range of activities was available, people were enabled to take part in ways they would not otherwise be able to. But when activities were reduced, people were left unoccupied. This happened when there were fewer staff on duty. Staff appeared 'task focused' and compelled to get jobs done before they could do anything else, consequently leaving people on their own for longer periods.

We noted one person had been admitted inappropriately and this had led to a situation where staff were unable to meet the person's needs, impacting on everybody who used the service. Records showed both the registered manager and deputy manager had been to assess him, and he had visited the home. They told us that they had not been made fully aware of his behaviours prior to his admission but they had seen risk assessments, and they accepted that they should have found out more about him. They stated that this was a lesson for the future.

We considered this poor assessment alongside the poor records of training and appraisals, the fact that the PEEPs were not up to date and the ongoing problem of staff morale and sickness. We found there was a

breach of Regulation 17(1) and (2)(b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked what measures were in place to monitor the quality of the service. The cleaning of the home was checked daily using a checklist. We saw on recent days that the checklist had not been ticked to show the audit had been done. When we asked about this we were told this was due to the "huge amounts of paperwork" that had to be done in relation to recent incidents at the service.

Spot checks of MAR sheets were done at irregular intervals, which meant staff did not know when they would happen. There was space to record "action to be taken" but we were told this had never arisen. There was a health and safety checklist completed every two months. First aid boxes were checked every month.

The maintenance manager, who was based at the provider's head office in Harrogate, came to do periodic checks on the building.

Care plans were reviewed yearly, although the records of these reviews were incomplete. The reviews were intended to identify whether anything had changed. If it had, staff were informed and the change was written in a communication book. There was scope for the reviews to go further in terms of assessing the quality of the care plans. For example, on one care plan there was a contradiction about what to do in a particular medical emergency, which had not been picked up on review. This could potentially have been important if staff read the wrong instructions. This was immediately corrected when we pointed it out.

We understood there were regular visits by the Head of Housing and Support to assess the quality of the service, but no reports of these visits were made available to us within the home.

The policy file was available in the office. The file would benefit from an index to help locate individual policies. There were signatures to indicate that the policies had been reviewed, but no dates. The date that the policy should next be reviewed was not shown. There was no record on the file to show that staff had read any of the policies. Some new policies had been introduced at the staff meeting in April 2016. This was recorded in the minutes for the benefit of staff who missed the meeting.

We saw minutes of staff meetings held roughly every three months. There were no agendas attached to the minutes. Nor was there attendance listed on the minutes, so it was not possible to see how many staff had attended.

The registered manager understood the requirements to report certain types of incidents to the CQC. There had been very few such notifications in recent years, but three recent safeguarding incidents had been reported in sufficient detail. We mentioned earlier an incident which had not been correctly identified as a safeguarding incident. We were not aware of any other notifiable incidents which had not been reported.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs. There was a lack of suitable activities. Regulation 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider was not treating the service users with respect and supporting their autonomy and independence Regulation 10(1) and (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A service user was being deprived of their liberty without lawful authority Regulation 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not adequately assessed the risks relating to the health and welfare of service users, and had not maintained necessary records. Regulation 17(1) and (2)(b) and (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate training to enable them to carry out their duties Regulation 18(2)(a)