Mental Health Care (U.K) Limited

Acrefield House

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 16 and 17 November 2017. The first day of the inspection was unannounced.

Acrefield House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home is a large Victorian style building over three floors in a residential location. The home is registered to provide care and accommodation for up to 12 people. At the time of our inspection nine people were living at the home.

The home requires and had a 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.

The previous inspection was in February 2017. During the previous inspection the service breached regulations 11, 12, 13, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found breaches of Regulation 18 of Care Quality
Commission (Registration) regulations 2009. Failure to notify the Commission of notifiable incidents.

At this inspection we found that improvements had been made. This meant the service was no longer rated inadequate and could be removed from 'special measures' by the CQC. The service was no longer in breach of Regulations 11, 12, 13, 16 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. And Regulation 18 of Care Quality
Commission (Registration) regulations 2009.

At this inspection we found that there were breaches of Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the language and approach of staff both verbally and in written care plans did not always treat people as equals with dignity and respect. We saw that relationships between people and staff at the home were friendly and that staff cared about people; however the predominant approach towards people was paternalistic. We recommended that there needs to be a greater focus on dignity and respect in the language and approaches used when supporting people.

We looked at the record of incidents that had happened at the home since our previous inspection. We saw that the number of incidents had reduced. The response to incidents from the registered manager and the provider had improved. Incident records showed that the manager and staff had taken time to explore the possible reasons that may have prompted a change in the person's behaviour. Records of physical interventions did not always give a clear picture of what happened or had led to updates to people's risk assessments or care plans. Also the rationale for decisions made in supporting a person were not clearly recorded to show that they followed the best interest decision making process as outlined in the Mental Capacity Act.

You can see what action we told the provider to take at the back of the full version of the report.

During this inspection it was clear that the registered manager and staff had worked hard to make improvements to the service provided to people. During this inspection we saw that there had been improvements in the culture and atmosphere at the home. People's family members, staff and health and social care professionals spoke positively about the registered manager and his style of communication. One person's family member told us, "When [registered manager] came in it stepped up a level and communication improved. They have always been available for us when we need them." We did see that new thoughts and ideas of different and more person centred ways of supporting people had been written on the plans and there was a culture starting to develop of trying new ways of supporting people.

A number of processes and audits had been introduced or strengthened by the registered manger. Some of these audits had been effective and others had not highlighted the areas that we saw that required further improvements.

Staff told us that they felt well supported in their role. There was a clear system in place for monitoring staff training and ensuring staff undertook and remained up to date in areas the provider considered mandatory.

People were supported with their health needs; important information about people's health was kept in a central place. People's relatives were happy with the way their family member was supported with their healthcare. One relative told us, "They [staff members] are quick in spotting problems and getting medical attention."

We saw that people were supported to access their community and lead active lives. People told us what they enjoyed doing. One staff member told us, "People do more now that they used to do." One person's relative told us, "They are amazing in terms of keeping [name] involved. They arrange for [name] to go to all the home games of his local football club with support. He loves this." Another relative told us the staff enable the family member to have a, "Really good quality of life, [name] enjoys it."

The registered manager and the regional manager that we spoke with and gave feedback to were open, honest and transparent when we discussed areas needing further improvements. They told us that the service is not where they want it to be, but described plans that are in place to make those changes.

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.

Records of physical interventions did not always give a clear picture of what happened and had not led to updates to people's risk assessments or care plans.

Risk assessments did not always reflect the daily care a person received.

Communication with regard to safeguarding vulnerable adults and incidents at the home had improved. The service was more responsive in this regard.

There were sufficient staff members at the home, who had been safely recruited to work with vulnerable adults.

People's medication was administered safely and the home's environment was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had not always recorded how the principles of the Mental Capacity Act were followed in its support of people.

Staff received support in their roll through training, staff team meetings and supervision meetings.

People were supported promptly with any health needs and there were clear health documents in people files.

The environment of the home was suitable for people's needs.

People told us they liked the food, which looked and smelt appetising.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw that people were treated nicely in their day to day interactions with staff. People's relatives told us that they felt there was a caring atmosphere at the home and they were always made to feel welcome.

During this inspection we saw that there had been improvements in the culture and atmosphere at the home.

People were not always treated with dignity and respect. Whilst we saw occasions when people's autonomy and choices were promoted we also saw occasions when personal freedoms and rights were not respected.

There were regular service user meetings; these were used to gain people's feedback, opinions and to plan upcoming events.

Is the service responsive?

Good

The service was not always responsive.

People had individualised care plans that were regularly reviewed. These reflected people's support needs and preferences in their lives.

People engaged in a wide variety of day to day and leisure activities in their local communities.

There was information available on how to raise a complaint in a variety of formats.

Is the service well-led?

Requires Improvement

The service was not always well-led.

During this inspection it was clear that the registered manager and staff had worked hard to make improvements to the service provided to people.

Further improvements were required in regard to the culture of the home. Practices that didn't treat people with dignity and respect had not always been challenged.

Some of the checks and audits at the home had not been effective in highlighting areas of improvement. Some of the exploring of incidents or significant events had not improved people's support.

The registered manager and the regional manager that we spoke with and gave feedback to were open, honest and transparent

when we discussed areas needing further improvements.

Acrefield House

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 checked 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 16 and 17 November 2017, the first day was unannounced. This was a comprehensive inspection following the rating of inadequate from the previous inspection in February 2017. We inspected to check if improvements had been made in line with the provider's action plan which had been regularly shared with the CQC.

The inspection was completed by two adult social care inspectors and an assistant adult social care inspector. Before our inspection we obtained the view of the service from the local authority quality assurance team following their recent visits. We checked our system and looked at the information we had received from the service since our last inspection; including statutory notifications from the service. We looked at the care plans for four people, recruitment records for three staff members and other records relating to the management of the home.

During our inspection we spoke with six people who lived at the home. We spoke with ten members of staff including the regional manager and the registered manager. We spoke with one visitor and one person's social worker. After our visit we spoke with three people's relatives on the phone.

Requires Improvement

Is the service safe?

Our findings

People who we spoke with told us or communicated that they felt safe living at Acrefield House. People's family members told us that they felt their relative was safe and happy at the home. One relative told us, "I am confident that [name] is happy there." Another person's relative said they felt confident because the "The staff are alert and very responsive."

At our previous inspection in February 2017 we found that safeguarding alerts from staff members to the registered manager and other events that would reasonably be considered safeguarding alerts; had not been investigated by the then registered manager or reported to the local authority, health and social care professionals involved in people's care or the Care Quality Commission. This meant that safeguarding issues had not been properly addressed.

Since our previous inspection communication with family members, the local authority, health and social care professionals and the Care Quality Commission has improved. This is in regard to safeguarding, incidents and other matters. The current registered manager has been described by people's family members, staff members, social work professionals and the local authority as a good communicator and the service has improved in this regard.

We looked at the record of incidents that had happened at the home since our previous inspection. We saw that the number of incidents had reduced. However there were still a number of physical altercations between service users and on four occasions over a two week period staff had to physically intervene with one person for their safety and the safety of other people living at the home.

The response to incidents from the registered manager and the provider had improved. Incident records showed that the manager and staff had taken time to explore the possible reasons that may have prompted a change in the person's behaviour. They explored potential medical, social and environmental causes. The person's GP and other health care professionals had been quickly informed and involved to explore if there were underlying reasons for the change in the person's behaviour. This showed that the staff and registered manager had a more person centred response to these incidents.

Physically intervening to stop or hold a person is a serious step to take and should only be made using a recognised and authorised technique, with the minimum amount of force for the shortest period of time. When we asked the registered manager questions about the incidents he was able to clearly explain why the decision had been taken to physically intervene, how this had been the least restrictive option and how this had been used as a last resort. The registered manager's explanation was thorough; however these incidents and the response of staff should have been more clearly documented in the incident reports. Records of physical interventions did not give as clear a picture as when we asked the manager.

We did however note that the incident records and the analysis of the incidents had not taken into account the person's physical condition and any illnesses that they had. This had also not been taken into account when reviewing the person's risk assessment. There was no clear record of formal or informal de-briefing for

the person or staff members involved; although a couple of staff members told us that they had been debriefed after incidents. One staff member told us, "I had a good debrief."

We saw records of and staff told us that since our previous inspection they had received more training in supporting people in challenging situations. They had attend regular meetings were recent incidents had been reviewed and they looked for themes and patterns and used a cause root analysis tool. Staff told us that this training and process helped them and they now, "Feel more confident."

Any marks, scratches or bruises on a person's body were recorded on body maps. We looked at a recent record for one person who had some unexplained small bruises and scratches. Whilst these had been recorded by staff the cause of them was not known and there were no clues in the person's daily records to indicate how these may have happened. There was no record of how staff had explored the cause of these marks, what actions had been taken and if the person had been asked about them.

We spoke to the registered manager about the practice of following up on any bruises that staff noticed. Unexplained bruises, the manager told us, would be documented and observed with information being handed over to the next team at shift handover. He also explained that the service now receives weekly home visits from a GP and that any concerns would be raised with them. On this occasion this had not been recorded.

We recommended to the registered manager and the regional manager that the records regarding incidents and unexplained marks should be as detailed as possible including information on what was explored and actions taken by the service, in order to keep people safe and for future learning and risk assessing.

People's care files had risk assessments that had been signed by the person's key worker, the registered manager and if appropriate the person themselves. We saw that some people's files contained a number of risk assessments covering a range of risks and scenarios. Often these were detailed, current and offered appropriate and thoughtful guidance for staff.

However at times the risk assessments and the daily care a person received was disjointed and the assessment did not reflect the care the person received. For example one person had nine risk assessments on their care file for a variety of risks, these contained lots of information and were very detailed. However there a sensor on the person's bedroom door which alerted staff when the person left their room and the staff also made hourly checks on the person overnight. There was no record of the sensor and the overnight checks or the risk reducing rationale behind them in the person's risk assessments. The staff and registered manager could not explain what risks were being mitigated by hourly overnight checks. We recommended that the registered manager review people's risk assessments and ensure they reflected the care people received and balanced people's rights and freedoms with the potential risks.

These examples are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the service had not consistently maintained adequate records in respect to the care provided to people.

We saw that there were sufficient staff available to support people when at home and in their community. Staff appeared unhurried and had time to sit, chat and interact with people. We looked at staff rotas and saw that these identified who was the 'shift leader', who was designated as a first aider, who was responsible for medication administration and which staff were supporting people on a one to one basis during the day.

We looked at recruitment records for three members of staff who had started working at the home since our previous inspection. These records showed that new staff had completed an application form, undergone an interview process and had their identification checked. The registered manager also arranged for a Disclosure and Barring Service (DBS) check and for references showing the applicants conduct in previous employment. These recruitment processes helped to ensure that new staff were suitable to work with vulnerable adults.

Staff members we spoke to told us they had received safeguarding training and they appeared confident in following relevant procedures that would keep people safe. Staff members also appeared confident in being able to raise concerns outside of the organisation if they thought that the matter was not being addressed effectively. Staff had access to and were able to show us the service's safeguarding and whistle blowing policies.

Medication was stored safely in a locked room or in locked cabinets in people's bedrooms as appropriate. We looked at a sample of people's medication administration records and checked them against stocks on hand. The stocks were correct which indicated that people had received their medication as prescribed. Information and guidance on the medication people had been prescribed was available for staff to use. Senior staff who administered medication received training in the administration of medication; their competency was checked and recorded during observations.

Details of people's medication was well documented and regularly reviewed. Each person had an individual medication assessment on their file, we saw that these were detailed. One person was taking medication which was outside of the national guidelines (as highlighted in the British National Formulary), this had been documented and a review of the person's medication with health care professionals had been prompted by the service, leading to a reduction in the amount of medication a person was taking. This showed that these reviews had been effective.

We looked at the records for the use of 'as and when required' (PRN) medication for times when people may be anxious and to help them become calm. Nobody was using medication in this manner frequently and there was not any unexpected patterns that may indicate underlying problems were being masked with the use of medication.

The environment at the home was clean and well maintained. We saw records and certificates that showed appropriate audits and safety checks had taken place. Each person had a personal emergency evacuation plan (PEEP), which contained details that may be needed to keep a person safe in the event of an emergency. We saw that staff used personal protective equipment to promote infection control, for example disposable aprons and gloves when assisting people with personal care.

Requires Improvement

Is the service effective?

Our findings

From our observed interactions it was clear that people had positive relationships with staff members at the home. People's relatives were positive about staff members. One family member told us, "They [staff members] communicate well, they keep me up to date." Another family member told us, "I've found them [staff members] to be responsive. It's the best place [name] has been, it meets his needs."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at documents that showed people's capacity to make a decision had been assessed if there was a reason to do so. If people had not been able to consent to their care and accommodation a DoLS authorisation had been applied for from the local authority showing the rationale of how the decision made was in the person's best interests.

In other decisions made on a person's behalf there was no clear documented process of how the decision had been made. There was no recording of any practical steps that had been taken or considered to support the person to understand the particular decision that needed to be made and how the person was supported by making the information meaningful to them.

The best interest decision making process as outlined in the Mental Capacity Act had not always been documented so that it was clear or the registered manager was able to explain how they were confident that the decision was in the person's best interest and the least restrictive option. For one person the practice of placing a restriction on one area of their life had been inherited from a previous care organisation. The person's social worker had been involved in this decision. A clear rationale for the decision had not been recorded in the person's care plan; this is despite the person acting in a manner that could reasonably indicate they object to the restriction that is in place.

The registered manager immediately contacted the person's social worker and other health professionals on the same day to gain more information to compile accurate records in the person's care plan. However it is concerning that such gaps in a person's care plan had not been highlighted when being reviewed internally.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the service had not maintained adequate records in respect to a significant decision made in relation to a person's care.

The registered manager spoke positively about staff supervision and taking opportunities to support staff. Records showed that all staff had received regular supervision meetings with a senior member of staff. Staff told us that these meetings had taken place and they had found these to be useful and had been able to use them to discuss a variety of subjects. Staff told us that they received a lot of support when they first started at Acrefield House. One staff member told us they received two weeks mentoring by shadowing a more experienced staff member in addition to two weeks training.

The registered manager told us that as well as formal supervision meetings there was also monthly staff forums and the use of incident review meetings and handovers. These meetings were used as opportunities to support staff and ensure that they have the best information to be able to support people well.

A clear system was in place for monitoring staff training and ensuring staff undertook and remained up to date in areas the provider considered mandatory. The provider had a training department that organised monthly training sessions that staff could be allocated to when any training was due. The majority of staff had obtained a national vocational qualification in care. The training matrix showed that staff had undertaken training in a variety of areas for example; food hygiene, fire safety, health and safety, infection control, moving and handling, equality and diversity, the Mental Capacity Act, mental health awareness, safeguarding and medication administration. There had been refresher training for staff in a recognised method of how to support people during challenging situations and as a last resort how to physically intervene in a safe manner. Staff told us that attending this annual refresher made them feel more confident.

Each person had a 'Health Action Plan' in place. We looked at a sample of these. These also contained details of the persons last regular health check. Notes were kept in people's files of any visits or communication with their GP and the outcome or any recommendations arising from these appointments. This meant that important information was kept in a central place. People's relatives were happy with the way their family members had been supported with their healthcare. One relative told us, "They [staff members] are quick in spotting problems and getting medical attention."

We saw that some people's care plans contained a document on, 'How I experience and deal with pain.' The document we looked at was detailed and contained information and guidance for staff on what was known about the person communicating that they were in pain, guidance on pain relieving medication and examples of what the likely cause may be.

The registered manager and some staff members told us how they worked with health professionals to promote people's wellbeing and access to medical professionals. For example there was a weekly visit by a GP to support people's health and wellbeing. We understand the rationale for weekly visits to the home by a GP and can see some of the benefits of doing so. However we highlighted to the registered manager that many people were able to visit their GP in their community in the usual manner when it was felt necessary to do so; the weekly visit to check on people's health because they had a disability was an institutional approach to people's healthcare.

Adaptations had been made to the building to support people with their mobility and personal care. For example adapted showers were available so people could access them easily. Equipment such as fixed and mobile hoists and a portable ramp were available to meet people's current and future mobility needs. Keypads and locks were kept to a minimum within the home so that people could freely use communal

areas of their home without restrictions. The garden provided a safe secure space that people could enjoy.

There was an almost overwhelming amount of information on a series of notice boards along corridors, in addition to the notice boards in the staff room. There was information on advocacy, recent CQC reports, Information on how to contact the Nominated Individual, pictorial posters providing information about advocacy, complaints and the role of and how to contact the CQC. There was information for staff from the local police service, for employees to whistle blow, the local parish magazine, how to raise a concern with the NHS, NHS safeguarding adults information, the recent 'state of care' report, the floor plans of the building, pictorial food menus, pictorial activity planners and details of Makaton signs. Whilst it was understandable why the information was displayed, the style of display and amount of information was overcrowded, difficult to read and contributed to the home looking more clinical and less homely.

People indicated to us that they liked their rooms; one person gave us a tour of their room that they had decorated in preparation for Christmas. People's relatives told us that they thought the standard of accommodation was good. One person's family member told us, "[Name] has his own room, it's nice and well furnished." Another relative told us, "The building is lovely and kept clean."

Since our last visit the kitchen had been refurbished. The local authority had awarded the kitchen the highest award of five stars, for food safety and cleanliness. The home had a kitchen that was domestic in appearance; although we did not see anyone living at the home using the kitchen staff told us that people did. Food was generally ordered online from a supermarket however staff again advised us that people living at the home made use of local shops to buy additional food as needed.

Meals looked and smelt appetising and we saw that there was plenty of food available. We observed part of the lunchtime meal and saw that people had different meals according to their needs and wishes. Where people used prescribed nutritional supplements this was clearly recorded. One person had their fluid intake monitored daily. Records of this had not always been completed or tallied up at the end of the day. This meant that staff could not be sure the person was getting the correct amounts of fluid they required. We highlighted this to the registered manager who assured us that the recording would be amended.

Requires Improvement

Is the service caring?

Our findings

We saw that people were treated nicely in their day to day interactions with staff, which were positive and friendly. People appeared relaxed in the home and comfortable with staff members. Many people had lived in the home for a long time; some up to 20 plus years. People living at the home told or communicated to us that they were happy and liked living at the home and liked the staff supporting them.

People's relatives told us that they felt there was a caring atmosphere at the home and they were always made to feel welcome. One family member told us, "I visit regularly. I'm always made to feel welcome. The staff make me welcome, they are good staff." Another relative told us, "The care is first class. I've no complaints at all about the care [name] gets." A third relative told us, "They are really welcoming. We come at different times and the staff always offer us a drink and spend some time with us."

One person's social worker told us, "I feel [name] is happy at Acrefield. Compared with the previous place [name] lived this is so much better; it's like night and day. They try really hard in a person centred way for him." One member of staff told us that the, "Atmosphere was now more relaxed and friendly." And, "The atmosphere is much better amongst staff, the infighting has calmed down."

During our previous inspection we found that the atmosphere had been tense. There was a poor culture amongst the staff team; many staff told us about divisions and infighting amongst the staff team. Staff told us that this must have had an impact on the atmosphere in people's home.

During this inspection we saw that there had been improvements in the culture and atmosphere at the home. The atmosphere at the home was calm and relaxed, people seemed comfortable and at ease. We saw positive interactions between staff and people living at Acrefield. For example staff took time to sit with people and encourage them to take part in arts and crafts activities as well as spending time in the lounge with people socialising. Staff that we spoke with confirmed this. One staff member told us that since our previous inspection the home was now, "A lot more settled. There is a nicer atmosphere and we are now working together as a team. People are more relaxed; it's definitely had a positive impact on people." A regular visitor to the home told us, "It has settled, there is a lot less friction between staff members."

Whilst we saw occasions when people's autonomy and choices were promoted we also saw occasions when personal freedoms and rights were not respected. People living at Acrefield House were not consistently treated as equals of the staff paid to support them. This principle of equality and respect was not embedded in the culture of the home. There was a paternalistic approach were the staff or the 'service' knew best and would at times restrict people's freedom in what was thought to be their best interests without exploring this appropriately.

For example staff completed hourly checks on a person overnight by listening to them from behind their bedroom door. We looked at notes that were made of these checks and on one night they included the comments; 'Listened all quiet in his room'; 'listened from outside his room, all quiet' and 'quiet in the room as listened'. When we spoke with staff they were not able to tell us what they were listening for and what

potential risks there may be. There was no risk assessment that had identified risks or provided guidance for staff on the person's overnight risks. The person was not at risk of seizures, falling, self-harm or any other specific overnight risk. If the person left their room and needed support, assistive technology alerted the night staff. The registered manager told us that there was no rationale for these observations other than the staff were in the habit of doing them. The person was not aware of these hourly observations made of them during the night. This was an infringement on the person's privacy whilst in their own room.

Whilst staff members appeared to be well intended there were many examples of institutionalised language when talking to and about people and approaches that could be perceived as overpowering or even controlling. For example we introduced ourselves to one person and whilst they were expressing themselves with signs and expressions; the staff member interrupted them and told us that, "[name] is non-verbal and can't talk." Another staff member when talking about a person who they thought was unwell said, "I'm not going to send [name of person] to [activity]. I'm keeping her home." We spoke with the staff member and asked them if they had asked the person how they felt and they told us that the person is non-verbal and "does not communicate". A third staff member when talking about a person's behaviour told us, "[Name] likes to get a can of coke. If he behaves and does not swear or shout, he gets a can of coke. If he does swear or shout he does not get a can of coke, but we explain it to him. He then says, 'I'll behave'". We heard another staff member being directive to a person saying to them, "That's not where your coat goes."

For example on Friday evening when everybody had 'chippy' take away food the kitchen was ready for the food to arrive with two separate stacks of plates and cups. Staff had ceramic plates and tea mugs and people living at the home had cheap looking brightly coloured plastic plates and beakers. We asked a member of staff who told us that this was for safety reasons. We were told of one person who had thrown a plate and information in one person's care plan that said, 'I drink out of an ordinary beaker or a mug.' The use of plastic cups across the board differentiates people and is an institutional practice.

On the first floor one of the toilets was designated for use by staff, again this can be seen as an institutional practice that differentiates people for no good reason as all toilets should be in a condition that everyone can use. On two people's bedroom doors there were posters regarding the testing of electrical appliances. We also saw staff going out from and coming back to the home with identification lanyards clearly visible on top of their coat. It made a clear distinction between people and the relationship of the supporter and the supported to members of the public.

One person's positive behaviour support plan gave the following guidance for staff about one person when they are calm. The plan said, 'Don't let me fall asleep. Don't let me put my seat back in recline.' Another care plan for eating stated, 'I may signal for seconds but as I am on Weightwatchers I may not always be allowed.' The registered manager told us that this was a section of an old care plan and should not have been in the person's file.

These examples collectively demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because service users were not always treated with dignity and respect.

In summary this regulation is to make sure that people using the service are treated with respect and dignity at all times whilst they are receiving care and treatment. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous.

We gave feedback to the registered manager and the provider's area manager. They were both open and not

defensive when discussing this information. The registered manager told us that it was good to have the perspective from a "fresh pair of eyes". He told us that some of the care plan information we had looked at was old and should not have been in people's files. He also explained to us that the staff members have very positive relationships with the people concerned and the phrases used were poorly chosen and although they may sound disrespectful did not indicate a poor or disrespectful relationship. We acknowledge that staff had relationships with people that appeared very positive. It was also explained to us by the registered manager and staff that there are ongoing changes in the culture of the home. We recommended that there needs to be a greater focus on dignity and respect in the language and approaches used when supporting people.

Previously we saw that people's verbal and non-verbal communication was not always listened to and acted upon. On this inspection we saw that improvements had been made in this area. Whilst a more in-depth approach needed to be developed we saw that staff and the registered manager at times had questioned what people may be trying to tell them through their actions. In day to day conversations with people we saw that staff members were reading people's signs and were responding to what they were saying. One person shared stories with us in their own communication style while the support worker helped us understand, the staff member was supportive of the individual's communication style.

Some people at the home used Makaton (a form of sign language) to communicate. We saw that staff were able to understand people when they used Makaton. We saw from notice boards that staff were learning and practicing a sign of the week, to expand their vocabulary of Makaton (a form of sign language) signs so they were able to have more in depth communication with some people. This showed us that the provider was taking steps to communicate with people in a way they could understand.

There were regular service user meetings; these were used to gain people's feedback, opinions and to plan upcoming events. A good percentage of people attended the previous meeting and we saw that the notes had been produced in a pictorial format. Two people who didn't want to join in as a group had one to one update meetings afterwards. Important and day to day information was readily available for people in easy read and pictorial formats. We saw for example that information on how to express if you were not happy with something and the menu for the day were both available.

Good

Is the service responsive?

Our findings

Each person had individualised care files containing a lot of information about the person and how to support them in a variety of formats. The registered manager told us that each person's care file had been renewed since our previous inspection. One staff member described the process saying, "Everybody [staff] stopped and went back to the core information of what people are about and how we support them."

Each person had documents in two files. One file contained care plans and risk assessments, another file contained information that was added to daily, such as daily notes and food and fluid intake if documented. People's person centred plans had been signed as read by staff members. Care plans and risk assessments contained handwritten notes of new information or observations that staff had learnt and may be useful in supporting the person in a more person centred way. This showed that the care plans were 'live' documents and they were being used by staff members on a regular basis.

When people's support plans offered guidance for staff for when there are risks or challenging situations they focused on stopping the risky behaviour. There was no wider plan for supporting a person to develop the skills to respond differently or guidance on how the staff could support the person to meet their need in some different way. This at times led the language and tone of support plans towards that of stopping a person from doing something, rather than exploring alternatives, supporting a person to develop skills or exploring the underlying reason as to the cause of the actions the person was taking.

People's care files had a section on learning skills. This focused on what a person can do, what they are working on and what they want to do. However one visitor told us about different approaches from different staff members. That some have an enabling approach and others do things for people rather than with people or helping people. They gave an example of a staff member making a person's bed when the person was standing outside their room. How the person could have been involved in maintaining their room rather than staff members coming into the room and completing tasks. The registered manager told us that it was difficult at times for long standing staff who had known people for a long time to help people learn new skills rather than being in the habit of completing tasks for people.

Health and social work professionals input was sought in reviewing people's care plans; as well as those from people's family members. One person's relative told us, "We were involved in [name's] initial care plan and we have been to a review meeting when we discussed the plan and we were asked for our input."

One senior member of staff told us, "I like the new care plans. If we see something we add it and write on them. Previously we were told we couldn't do this. We are responsible to update the plans for three people each. The plans are reviewed every three months but we add to them in the meantime." One social worker told us, "The care plans in place are particularly good; they are always ready to change and try new things."

Care plans started off with the prompts; 'what's important to me' and 'how best to support me'. We saw examples of when care plans were detailed and documented people's preferences both large and small that were important to them. For example one person's care plan contained the detail; 'I like action or comedy

films. I pick my own seat in the cinema.'

People had a 'one page profile', which is a document that can be quickly read so that a staff member can have a good overview of the person, their preferences, lifestyle and their support needs. This document was very positive about people and had the sections; 'what people like and admire about me'; 'how to support me to stay safe, happy and healthy'; and 'what is important to me'.

Some people had their routines documented so that all staff were aware of their preferences and choices. There was guidance for staff both practical and in detail. For example one person's plan had the detail about them, 'I like to take my inhaler before my medication'. Another example was a plan that prompted staff that when a person appeared to not be happy to offer them the option of eating their meal in the lounge area to help them relax.

Some people's care plans and communication passports were written in a pictorial format if this helped the person to read them. The pictorial plan contained information on people likes, dislikes and lifestyle choices. It was person centred in that the service documented information in a format that the person could understand. The communication passport gathered learning about a person's communication style that may help staff to support them. We saw that the person was involved in producing the document along with staff members and the speech and language team if they were involved.

Staff told us that the service tries to match people supported with support workers who have similar interests. For example, one person liked to go fishing and likes to go out with fellow fishing enthusiasts; another loves dogs and therefore prefers working with dog people. Staff did tell us that the home tried to make this happen as much as possible.

Staff told us about some of the achievements people had made over the last six months. They mentioned how some people had started to "come out more" and not stay in their room for as long as they had previously. We also heard that one person had moved rooms, which was noted as being their preference. The person was very happy with their room and gave us a 'thumbs up' gesture when we talked about their room. One person's care plan review under the heading of 'what's working' documented that they had started going to the local cinema and local pubs in the evening and they had enjoyed doing this.

We saw that each person had a monthly report prepared by their keyworker. These look back at any concerns or achievements. We also noted that the report encouraged staff to think about "what has gone well" or "what has not gone well" over the previous month. Staff explained that ideally keyworkers will review person-centred plans and ensure changes in people's needs are documented and shared with other staff.

One person's relative told us, "They are amazing in terms of keeping [name] involved. They arrange for [name] to go to all the home games of his local football club with support. He loves this." Another relative told us the staff enable the family member to have a, "Really good quality of life, [name] enjoys it."

One staff member told us, "People do more now that they used to do." An activity coordinator was employed to work at the home. During our inspection we saw that people living at Acrefield were engaged in a number of activities with staff including arts and crafts and going out to various places in their local community. Photographs showed that people had been encouraged to take part in a wide variety of activities to suit their choices. For example people had been to concerts and on various day trips to places of interest. One person who enjoyed fishing was supported to obtain a fishing licence for a local fishing spot. We were shown pictures of them fishing at this spot. Staff we spoke to told us about new activities being

introduced into the home; for example a regular visit by people who provide sensory and group activities to develop people's confidence.

There was information available on how to raise a complaint in a variety of formats including in picture format. We saw that the service also had an easy read complaints policy, a copy of which was in each person's care file. We saw that the registered manager had promoted information on how people could raise a complaint including discussing this at service user meetings. We saw that any complaints received were documented and responded to.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was not working at Acrefield House during our previous inspection which found that the service provided to people was inadequate. During this inspection it was clear that the registered manager and staff had worked hard to make improvements to the service provided to people. During this time the registered manager had kept in regular contact providing updates to the Care Quality Commission and the local authority.

From our observations it was clear that the registered manager had positive relationships with people and had got to know them during his time at the home. We saw that people were comfortable around the registered manager and had friendly interactions with him.
Staff and family members spoke positively about the registered manager and his style of communication. One staff member told us, "The manager is the best manager I've ever had." Family members confirmed to us that they had found the registered manager to be open and candid. One person's relative told us, "There have been one or two problems. I've found them quite open; straight away they have phoned me." Another family member told us, "When [registered manager] came in it stepped up a level and communication improved. They have always been available for us when we need them."

One visitor told us, "[Name of registered manager] has helped to settle things. The stability is felt by people and he is willing to listen." We spoke with a social worker who told us, "[The registered manager], has done a brilliant job, the place has come on leagues." They added, "The communication from him is good. He always puts a lot of effort in to get me the information I need in a timely manner. Whenever anything happens he always communicates with candour."

The registered manager told us that their initial priority had been to, "Work out the home in terms of getting to know the staff and the people living here." They had used this information to develop new care plans with people and these now needed to be embedded into people's day to day support. We did see that new thoughts and ideas of different and more person centred ways of supporting people had been written on the plans and there was a culture starting to develop of trying new ways of supporting people.

The registered manager and the regional manager that we spoke with and gave feedback to were open, honest and transparent when we discussed areas needing further improvements. They told us that the service is not where they want it to be, but described plans that are in place to make those changes. The registered manager and regional manager listened to our feedback and welcomed it. The registered manager had ensured that copies of the previous CQC inspection report along with the current rating of inadequate were on display in a number of places at the home.

During feedback with the registered manager they told us that change is a process and they were happy with the progress they have made but they were aware that there are areas they needed to work on. They describe the culture of the home now as positive, encouraging and there were now clear expectations of what the service expected of staff. The registered manager told us they were working to change the long-standing culture of the home, but acknowledged there are still pockets of institutionalised approaches.

We asked the registered manager their planned methods for further developing the culture. They told us their focus was more exploring of ideas and training with staff, using quality assurance as a second pairs of eyes and making full use of internal processes and systems such as incident recording, care planning and risk assessing to learn about people.

A number of processes and audits had been introduced or strengthened by the registered manger.
We saw how medication error reports had been used to learn and further develop their system. Also the registered manager told us that a different person's care plan was reviewed each Monday morning; this meant that people's care plans were reviewed about every two months. Each person's care file had copies of the incident forms involving them which had been reviewed.

Whilst there had been definite improvements in the registered manager's checks and audits of the quality of the service. They had not always been rigorous enough to address the institutionalised approach and language used within people's support and care plans and to question the reasons why people were supported the way they were. The system in place had not always ensured that learning from incidents had prompted a review of people's care plans.

The registered manager told us that previously the service had "not tied things together" in relation to incidents and now they were working out "what people are telling us." We saw recent records of Incident review meetings, which had led to some options being explored of things that had worked to prevent situations escalating and helping people to remain calm.

The home is registered to provide care and accommodation for up to 12 people, with one communal lounge and dining room. The provider is planning to reduce this to 11 people and use a bedroom as more communal space. The people who live at the home have a wide variety of support needs including learning disability, autism, acquired brain injury and mental health support needs. There is also a wide variety of people's ages and differing lifestyles. Although they have lived at the home for some time; five of the nine people living at the home came from outside of the local region and were some distance from their original home communities. Some people's relatives have to travel a large distance to see their family members. We discussed with the registered manager who the service was designed for and how they plan to meet the needs of a diverse group of people in one building. How would they decide if they were the right home for the next person who it is suggested should move into the home? We recommended that the registered manager give consideration to the values that underpin the 'Registering the Right Support' and other best practice guidance. Including the principle that people with a learning disability and autism using the service are able to live as ordinary a life as any citizen.

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 10 HSCA RA Regulations 2014 Dignity and respect This is because service users were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is because the service had not maintained adequate records in respect to the care provided to people and decisions made in relation to people's care.