Lifeways Inclusive Lifestyles Limited

The Merchant's House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 23 and 30 November 2018 and was unannounced.

The Merchants 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 home is registered to provide support for up to six people. At the time of our inspection five people were living there.

The Merchants House is a large Victorian building that fits in with other houses in the local area. People living there each have their own bedroom and share communal living space. There is off road parking available for several cars and an enclosed back yard people can access.

The home does not have 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. A manager had been appointed and had commenced the process of applying to register with CQC.

The last inspection of the service was carried out in August 2017 and the service was rated requires improvement. At that inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 19. This was because the service lacked a clear and robust system for monitoring and managing criminal records checks, known as Disclosure and Barring Service (DBS) records, and, where necessary, assessing any associated risks. At this inspection we found the service was no longer in breach of Regulation 19. This was because the manager was aware of information contained in DBS checks and where needed a risk assessment had been completed.

In June 2017 CQC published Registering the Right Support. This along with associated good practice guidance sets out the values and standards of support expected for services supporting people with a learning disability. At this inspection we assessed the service in line with this guidance.

During this inspection we found breaches in relation to Regulations 9, 10, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems for keeping people safe were not robust. This was because the provider did not keep sufficiently detailed records of incidents when people were physically restrained. No robust system was in use for reviewing accidents or incidents, including the use of restraint. This meant it was not possible to ensure people received support in the least restrictive and safest manner.

Records relating to people living at the home were not detailed or accurate. This included records for

supporting people with their behaviour and records relating to monitoring people so that their actions could be analysed and interpreted. We also found that records of people's weight were duplicated and had not been completed in line with the provider's review periods.

Other records relating to the operating of the home were not in place, accurate or up-to-date. This included records relating to staff training.

Assessments of people's care needs had been carried out and comprehensive care plans were in place. We found that at times they lacked detail and had not been reviewed in a timely manner.

Not all parts of the environment had been safely maintained. A gas safety check that was due in August 2018 had not been undertaken by the time of the inspection. We also found that an external infection control audit of the service had highlighted a number of concerns. At this inspection we found that the provider had failed to implement effective changes to the way in which people's laundry was managed to minimise infection control risks.

Staff did not always feel supported by the provider. They told us that at times particularly when supporting people who can challenge they had not felt sufficiently supported. The provider had undertaken an audit of the service in November 2018 and this had also highlighted that staff morale was low.

Staff had not always received training to help them understand and meet the care needs of people living at the home. This included training in areas the provider considered mandatory such as safeguarding people as well as areas specific to individuals such as the use of restraint techniques.

Although people received support to go out and about and to undertake activities at home this was not always consistently provided in the way the person preferred. One person had an activity they particularly enjoyed and liked to do around three times a week. Records showed that they had not been supported with this in the four weeks prior to the inspection.

The provider did not always meet the requirements of the Mental Capacity Act 2005. Care records did not always reflect people's choices and opinions. A lack of records meant it was not possible to establish whether the least restrictive options had been considered for people. We also found that care plans that placed restrictions on people were not always reviewed in a timely manner and did not appear to have had a positive impact for the person.

A lack of oversight by the provider had led to potentially unsafe risks and care for the people living at The Merchants House. Systems for checking and improving the quality of care and support people received were not robust enough to identify concerns and affect change. As identified within the report we found a number of concerns relating to keeping people safe, minimising restrictions upon people, record keeping and oversight of the care and support people received to stay safe.

The Merchants House did not meet the values and principles of Registering the Right Support and associated guidance. These encompass the values of choice, independence, inclusion and living as ordinary a life as any citizen. This included staff wearing large bunches of keys and standing around when people living there were sitting down. This could create the feeling of a power imbalance between staff and people living there.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems were not robust enough to monitor risks to people's safety and establish if the support people received was safe.

Checks on environmental safety were not carried out in a timely manner and improvements plans were not always followed. Records were not well maintained, up to date or accurate.

Staff were recruited safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive the training and support they needed to understand and meet people's needs.

People were not always supported to make decisions and choices for themselves. People's legal rights were not always protected.

People had a choice of meals and enjoyed the meals provided. Support for people to monitor and meet their nutritional needs was not always clearly recorded.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider was not always following the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence, inclusion and enabling people to live as ordinary a life as any citizen.

At times staff practices and the support provided to people were institutional.

Some staff had built positive relationships with people living at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were not consistently supported to take part in activities that met their needs and choices.

Care plans and assessments did not always provide clear guidance and were not always reviewed in a timely manner.

People felt confident to raise any concerns or complaints that they may have and these were dealt with.

Is the service well-led?

Inadequate

The service was not well-led.

The home did not have a registered manager.

The provider did not have robust systems in place for overseeing and improving the safety and quality of the service provided.

The Merchant's 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 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 was prompted in part by information of concern we received about the home. This indicated potential concerns about the management of risks within the home. This included risks relating to the use of restraint, supporting people's legal rights, staffing levels and staff training. This inspection examined those risks. The initial concerns were referred to the local authority who undertook safeguarding investigations.

The inspection was carried out on 23 and 30 November 2018. The first day of the inspection was carried out by an Adult Social Care (ASC) Inspector and was also attended by an (ASC) Inspection Manager for a short period of time. The second day of the inspection was carried out by two ASC inspectors.

Prior to our visit we looked at any information we had received about the home including any contact from people using the service or their relatives and any information sent to us by the provider. This included the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also spoke to the local authority to ask them to share any relevant information they held about the home.

We used all of this information to create our 'planning tool' which helps us to decide how the inspection should be conducted and any key information we need to discuss.

During the inspection we looked around the premises and met with the people living at the home, one of whom we spoke individually with. We spoke with eight members of staff who held different roles within the home. Following the inspection, we spoke with a relative of one of the people who lives at the home.

We spent time observing the day-to-day care and support provided to people, looked at a range of records including medication records, care records for two of the people living there, recruitment records for four

members of staff and training records for staff. We also looked at records relating to health and safety and quality assurance.

Inadequate

Is the service safe?

Our findings

Some of the people living at The Merchants House had been assessed as requiring physical restraint in order to stay safe. We found records of times when restraint was used to be inadequate in terms of the details recorded. We looked at records for one person and were unable to establish the number of times they had been restrained and for what periods of time. A lack of robust record keeping means it is not possible to establish whether guidance had been followed.

We asked a senior member of staff to carry out an analysis on the use of restraint and they were unable to do this due to the inadequate recording. This meant that if the person had been restrained unlawfully or inappropriately then it would not be possible to tell. In not auditing and analysing the use of restraint in a thorough timely manner the provider is failing to safeguard people and ensure their human rights are protected.

On one occasion we saw a person lift their arm to their head, a member of staff stopped them and told us, 'We are not restraining [name]'. Restraint can be defined as, 'Any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.' We asked a senior member of staff why the person was not allowed to touch their head and they said they did not know of a reason. This concerns us as it indicated staff do not have the knowledge needed to understand when they are restraining somebody and when it is appropriate to use this.

The home operates a system whereby teams of staff work together on the same shifts. One member of staff told us that there were more incidents when one team was working than another team. As the provider had not analysed incident records in a timely manner or carried out a meaningful audit of incidents this information was not formally available. This in turn meant that no analysis of how the different approaches staff may take or differences in routines may impact on the person.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider failed to have systems in place to safeguard service users.

A policy was in place to advise staff on reporting safeguarding and we found they were aware of this and of the whistle blowing policy. Whistle blowing protects staff who report something they believe is wrong in the workplace and is in the public interest. One member of staff told us "It's my duty, I will always say." We found that the provider had reported potential safeguarding concerns and had co-operated with other agencies in dealing with safeguarding investigations. However as detailed above the provider did not have robust systems in place for checking that people's rights were always upheld.

Records we looked at were incomplete and did not contain the required information. This included records relating to times when staff physically restrained people, which were incomplete and lacked the detail required to safeguard the person. Charts were in place to monitor how one person behaved on a regular basis, these had not been completed with regularity. This meant that no overview of the person's daily life and what could affect their behaviours could be undertaken. We also found that incident forms had not

been reviewed and analysed as required.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider did not maintain an accurate, complete and contemporaneous record of the care and treatment provided to service users.

A gas safety certificate for the home was dated 18 August 2017 and should have been renewed in August 2018. This had not been noted until October 2018 when a series of emails had been sent internally to establish who was responsible for arranging this. At the time of the inspection no gas safety inspection had been undertaken at the home. This meant it was not possible to establish the safety of the gas supply and appliances within the building.

Records for checking 'Fire detection and alarm' stated the front door alarm should be checked weekly. This was checked in August 2018 and a note made stating, 'waiting for fire alarm keys'. It was next checked almost seven weeks later in October 2018. This meant the provider had not followed their own safety guidance for ensuring all fire systems and alarms were safe.

An external infection prevention and control audit of the home was carried out in October 2018. An overall score of 63 percent was given which is low and means that it should be given organisational priority. Although the manager had taken steps to address this including purchasing new laundry baskets and cleaning products this did not translate into improved practice at the home. On both days of the inspection we found unwashed laundry on the floor in front of the washing machine. This also included water soluble bags which are generally used for potentially infected laundry. Staff were unsure if these contained potentially infected laundry or not. Leaving unwashed laundry lying on a floor and mixed with potentially infected laundry increases the risk of cross infection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider did not take steps to ensure that the environment was safe.

Other safety certificate and checks had been carried out in a timely manner including checks on electrics, small appliances and hoists.

At our last inspection of the home in August 2017 we found that the service lacked a clear and robust system for monitoring and managing criminal records checks, known as Disclosure and Barring Service (DBS) records, and, where necessary, assessing any associated risks. At this inspection we found that this had been addressed and where needed risk assessments associated with DBS checks were in place.

We looked at recruitment records for four members of staff who had commenced working at the home recently. These showed us that staff had undergone an interview process and checks including obtaining a Disclosure and Barring Service check, references and identification had been carried out. These recruitment processes helped to check staff suitability to work with people who may be vulnerable.

We looked at how people's medication was stored, recorded and administered. At our last inspection of the service we had noted that 'as required' medication was not always recorded well. At this inspection we found records for recording the reason why 'as required' medication was given had improved.

We looked at a sample of medication and checked this against records and found these tallied indicating people had been given their medications as prescribed.

Medication was securely stored in a locked room. The radiator was on in this room and the room felt warm. No thermometer was available to check the temperature of the room to ensure medication was being stored within recommended temperatures. Storing medication outside of recommended temperatures can impact on its effectiveness.

We recommend that the provider follow good practice guidance for the storage of medications.

All of the people living at The Merchants House required one or more members of staff to support them at times. A member of staff told us that in order to provide the assessed levels of staffing for each person a minimum eight members of staff are required during the day. This included a team leader who can deal with the day to day running of the home including medications. A senior member of staff told us that they assessed the service as needing between seven and ten staff during the day.

A second member of staff told us that there were not always enough staff to support people safely. We have also received concerns about staffing levels from a visiting health professional to the home, a second member of staff and a relative. Some of these concerns relate to the fact that although working some staff are on restricted duties and therefore cannot meet all of people's support needs.

We recommend that the provider review staffing levels at the service to ensure they are sufficient to meet people's needs at all times.

Information on how to support people in an emergency was available in the home and staff were able to explain the actions they would take in the event of a medical emergency or fire alarm sounding. Staff were aware of the location of first aid boxes and fire meeting points.

Inadequate

Is the service effective?

Our findings

Staff working at the home did not always feel supported by the provider. Prior to the inspection we had received concerns about the home from an external professional. This included concerns about a lack of support for staff, particularly when they were supporting people who can challenge. During the inspection one member of staff told us, "I do not feel supported with people who challenge. It can be scary for me." Another member of staff said, "Support for staff [when injured] could have been better." A third member of staff said they felt supported, "To an extent." They added that prior to the new managers arrival they did not feel fully supported in terms of management. Following the inspection, we received concerns that also told us staff did not feel supported. An audit carried out by the provider in November 2018 had identified that morale amongst the staff team was low.

We asked for and were provided with a list of staff working at the home and a list of staff training. When we compared the names on these lists we found they did not tally. This meant it was not possible to audit staff training with certainty.

On looking at the list of training the provider considered mandatory this showed that a number of staff were out of date with some of their training. We noted that the list of mandatory training did not contain training in areas specific to the needs of people living at the home. This included understanding autism, brain injury and learning disabilities. We requested a list of training in these areas. This again did not tally with the list of current staff we had been given. We compared the two lots of information and found of the staff named as current only five staff had undertaken training in understanding acquired brain injury, no staff had received training in understanding learning disabilities and 17 had not undertaken training in autism awareness. Records indicated not all staff had received training in positive behaviour support and the use of specific restraints used.

Some of the training staff had received in techniques including restraint to support people had been undertaken between January and July 2017, a period of over 17 months. We did see that training had been organised for December 2018 in a range of techniques however it is a matter of concern that staff had not received a timely yearly update and some staff did not appear to have received training in these areas. This meant they may lack the knowledge to understand people and how their conditions may affect them, in addition it means staff have not had up to date training in techniques they are using to try to keep people safe from harm.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider failed to ensure staff received appropriate support, training and professional development to enable them to carry out their duties.

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards.

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 had the appropriate legal authority and were being met.

One person had a list of restrictions in their care plan, these were dated 2004 and were still in use. However, we were concerned that despite monthly reviews no improvements had been identified that could lead to the person having less restrictions in their life. The person themselves told us that they would like less restrictions in their everyday life. We did not see any involvement from the person or acknowledgement of their views within the plan.

People's capacity to understand and make decisions had been assessed. Where the person had been assessed as lacking the ability to make an important decision then a 'best interest' decision had been made. One person had two best interest decisions recorded. These had been completed with support from a relative and advocate as well as staff however they had not been signed and dated. This meant it was not possible to establish how accurate a reflection of the meeting they were.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider failed to ensure care and treatment of service users was appropriate, met their needs and reflected their preferences.

People who required the protection of a DoLS had this in place. DoLS we looked at did detail a number of the restrictions imposed on people's lives.

Records of supporting people with their weight were inconsistent and did not appear to have been followed up. One person was weighed in November 2017 with the next record being July 2018. During that time, they had lost weight. We did not see any further records of the person's weight to establish if they had continued to lose weight. A second person had three weight charts in their care file one for May 2018 and two for July 2018. We did not see further weight records for the person despite the fact that they required support to maintain their weight and their care plan stated they should be weighed monthly.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider failed to do all that is reasonable practical to assess and mitigate risks to service users health and safety.

The home employs a chef who told us that menus were planned with a Dietician employed by the provider. Lunch on the second day of our inspection included wraps and homemade coleslaw and the meals we saw looked plentiful and inviting. The chef was aware of people who had special diets and told us that they were catered for.

Care records showed that people were sometimes supported to bake or make a snack. The chef explained that people would bake or make a pizza at the dining table and staff would then take it to the kitchen to be cooked. Whilst this helps people to learn or retain some life skills it was not consistent and the fact that people could not access facilities to make a drink or snack let alone cook their cake meant this was more of

an activity than a meaningful learning experience that promoted people's independence and supported them to live as ordinary a lifestyle as possible.

Records showed that people had been supported to access health professionals as needed. The provider arranged for people to have access to professionals including a dietician, occupational therapist, physiotherapist, speech and language therapist and positive behavioural support practitioner.

Care records showed that people were supported to see health professionals and to attend appointments and tests. This included supporting people to see the district nurse, chiropodist, dentist and GP. We noted that one person's annual health check was last recorded as taking place in March 2017. This meant it was nine months overdue.

The Merchants House is an adapted detached house on a residential street in Prenton. It fits in well with other houses in the local area and is not identifiable as a care home externally. Internally shared space included a living room, dining room and bathrooms. Externally an enclosed back yard provided a place for people to safely spend time outdoors. People living there all had their own bedroom with en-suite facilities.

Adaptations were in place for people who needed them. This included a ramp and adapted bathing facilities. We did note that pictures and photographs displayed in the lounge were hung high on the wall and therefore would not be easy to see for people of an average height.

The building is based over four floors with laundry facilities in the basement, shared rooms and bedrooms on the ground floor with bedrooms also on the first floor and mezzanine level. The top floor was used as offices. During the inspection we did not see any concerns with the use of the building and layout. However, concerns have been raised with us by two people that the building is at times unsafe for people living there due in part to narrow corridors and staircase. We recommend that the provider keeps this under review.

Requires Improvement

Is the service caring?

Our findings

The provider was not always following the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence, inclusion and enabling people to live as ordinary a life as any citizen.

The way in which peoples care notes were written was at times negative and judgemental and did not show respect for them as a person or an understanding of how the person communicated and expressed themselves. For example, one person's notes included, 'Very mischievous and obsessive,', 'Being horrible to staff,' and 'Normal day, targeting self and staff.'

We visited one person's bedroom whilst they were out. We found that the bedroom had been left untidy and uninviting. This included bowls with dried remnants of food in them. The floor was littered with debris, including rubbish, clothes and a used towel. The bed had been used to store items including gloves, clothes, pads, wipes and blankets and the wardrobe doors had been left open. All of this contributed to making the room appear cluttered, untidy, uncared for and uninviting.

We looked at the person's bed which we were told they chose not to use. This was in an unacceptable condition including a stained sheet and mattress through which all the springs could be felt. The way in which the bed was made, the lack of comfort and the use of it for storage showed that staff were not supporting the person to maintain their bedroom so that it looked comfortable and inviting.

We saw examples of times when staff practices made the home appear uninviting and institutionalised. This included staff walking round with visible large bunches of keys and occasions when staff stood in the lounge or people's bedroom rather than sitting down. This gave an impression that they were watching people rather than supporting them and could be seen as creating a power imbalance.

We also noted that rather than using laundry baskets to support people to take their clothes to the washing machine staff routinely used water soluble bags. These are generally used for potentially infectious laundry and the routine use of these appeared clinical and not in keeping with supporting people's dignity or promoting the ethos of creating as ordinary a lifestyle as possible.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people did not always receive support that protected their dignity and respected them.

People living at The Merchants House had individual support from one or more staff during the day, which meant there were a lot of staff around the building. We saw some positive examples of this support. One person told us, "I like it here, I like going out, shopping." They told us they regularly enjoyed sitting with staff and having a cuppa. We also saw other people sitting with staff and chatting or discussing where they wanted to go that day.

Support for people to be as independent as possible was inconsistent. This could at times be limited for

people by the fact that some people had staff present with them 24 hours a day. One person told us that they would like to be involved in preparing their meals more. They explained that they currently had no facilities to do so and were aware the manager intended to put a toaster in the dining room. We discussed this with the manager who confirmed the plans to add some facilities to the dining room for people to make snacks and drinks. The fact that these were not already available demonstrated that the provider did not consistently support people to be as independent as possible and to learn and retain life skills. This is not consistent with the values promoted by Registering the Right Support and associated guidance.

One person told us, "I would like to have time on my own." Their care plan stated that they needed staff with them at all times in order to keep them safe. We did not see any evidence within their care plan that alternative approaches had been considered for the person and discussed with them. This means staff had not explored ways to provide people with some privacy.

Care plans referred to staff using sign language to communicate with two people. We asked a senior member of staff about this and they explain that two people used a mixture of recognisable Makaton signs and their own signs. We looked at one care plan and could see no information within the plan of the signs the person used. We also saw no evidence that staff had received training in supporting people using sign language.

Although not consistent we did see some areas in which people were supported to learn or retain life skills. This included a separate washing machine and dryer in the basement that one person living there used. The person also told us that they liked to keep their room clean and tidy and staff helped them to do this. We also saw that one person living at the home liked to collect recycling and staff helped them to collect this. They had been provided with outside storage for which they had the key and could use to pursue this hobby.

Where people had the ability to use keys they had a key to their bedroom, storage and a fob for the front door. We observed that staff stood back and supported the person to open their front door and greet visitors thereby giving people some sense of control over their home.

Requires Improvement

Is the service responsive?

Our findings

The provider was not always following the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence, inclusion and enabling people to live as ordinary a life as any citizen.

Individual care plans, risk screens and positive behavioural support plans were in place for people living at the home. These were all comprehensive documents however we found that in places they lacked detail or meaningful review.

People living at The Merchants House could act in a way that could cause harm to themselves or others. In order to support people, the provider used an approach called Positive Behaviour Support. As part of this approach a number of plans were in place for individuals that restricted their rights or meant they could be physically restrained. We did not see any evidence within the person's plan that less restrictive means of supporting them and keeping them safe had been considered taking into account their expressed views.

Examples of this included reacting to a person with pain rather than reviewing their records and having a plan in place to minimise the occurrence of this pain and risk screens not being reviewed at regular intervals.

We did not see any evidence that plans in place that included restrictions for people had had a positive impact on their lives. The way in which plans were written sometimes focused on staff actions rather than giving the person choice and control and working in partnership with them.

One person liked to take part in a particular activity and the manager told us they should be supported to do this up to three times per week. We looked at the person's daily notes for October 2018 and found no recorded occasions in which the person had been supported to enjoy this activity. Although the person had been supported to go out to other places the fact that they had not received the support their care plan indicated they enjoyed and which staff told us the person found most enjoyable shows that the home was not responsive to the person's needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider failed to provide care and treatment that met the person's needs and reflected their preferences.

During the inspection we saw that people were supported to go out and about in their local community and to take part in activities arranged in the home. For example, during our inspection three of the people living there went out individually with staff support.

One of the people living at The Merchants House told us that they liked the staff team and would feel confident to tell them about anything they were not happy with. They said that staff would 'Sort it' for them. The home had a complaints procedure in place which provided people with information on how to raise a

complaint or concern and the details of how it would be investigated.

Inadequate

Is the service well-led?

Our findings

The Merchants House did not have 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. A manager had been appointed and commenced work at the home in October 2018, she had worked at the service for approximately six weeks at the time of the inspection. The manager was in the process of applying to CQC for registration.

We found that a lack of oversight by the provider had led to potentially unsafe risks and care for the people living at The Merchants House. This included a lack of oversight of the use of restraint for people living at the home. We found a number of breaches of regulations at the home that robust quality assurance systems would note and address. This included lack of overview of incidents and accidents, poor record keeping, health and safety checks being out of date, staff training not being up to date and concerns regarding staffing levels. A health and safety audit of the service was carried out in November 2018 in which they gave themselves a score of 39 and a rating of 'poor'. Issues noted included water temperatures not being recorded, plans and risk assessments requiring updating, reading and signing, lack a gas certificate and a negative staff culture within the home. It is a matter of concern that these issues were noted In November 2018 and the provider had not had robust systems in place to prevent them occurring.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider failed to have systems in place to assess, monitor and improve the quality and safety of the service provided.

The provider had not always notified the Care Quality Commission (CQC) of incidents that had occurred in the home in accordance with our statutory requirements. This included not notifying us of an incident during which one person had left the building unaccompanied. This meant that CQC were unable to accurately monitor information and risks regarding The Merchants House.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is because the provider failed to notify the commission of incidents that occurred whilst carrying out a regulated activity.

We received concerns from a health professional who visited the home. These concerns included the fact that the provider did not always work well with other professionals in planning people's care and arranging for staff to attend sessions with members of a person's multi-disciplinary team. We noted that care plans for supporting people to manage their behaviour contained little evidence of involvement from a multi-disciplinary team. Although a senior member of staff told us that this occurred there was no evidence that advice was routinely obtained and followed from other professionals.

Staff were positive about the new manager. One member of staff told us, "Much more confident, [she is]

always there to answer anything. There was a lack of guidance, [manager] goes above and beyond." A second member of staff told us they felt things had got, "Positively better," since the arrival of the new manager.

We found the appointed manager to be open and transparent about the service provided at the home. She had identified a number of concerns that we identified at this inspection and was able to tell us of some of the things she had planned or was exploring to improve the service people received. This included providing basic facilities for people to make a drink and snack and exploring ways to make a person's bedroom safer. However, at the time of the inspection none of these ideas had yet been implemented.

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.