Orchard Care

Orchard House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 24 and 30 January 2018. The first day of the inspection was unannounced. This meant staff and the registered provider did not know we would be visiting. Orchard House is a residential care home and provides support to adults with a learning disability and/or autistic spectrum disorder. The service can accommodate up to ten people. At the time of the inspection nine people were living at the service. People in this care home receive accommodation and personal care as part of their contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Orchard House is two terraced houses that have been converted into one building.

At this inspection we found six breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating of the service is 'Inadequate' and the service is 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 any of the five key questions it will no longer be in special measures."

There was a registered manager employed at the service. 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.

People we spoke with told us they felt 'safe' and did not express any worries or concerns.

Although people told us they felt safe, we found the premises and equipment were not clean or properly maintained. We also saw the premises would be challenging for people who had poor and decreasing mobility. The fire officer had also visited the service in November 2017 and asked the registered provider to make a range of improvements to make the service safer. The registered provider was still in the process of making these improvements.

We found the registered provider had not ensured that staff received regular safeguarding refresher training to ensure they had an understanding of their responsibilities to protect people from harm. At the time of the inspection the registered manager was liaising with the local authority in regards to providing staff training.

We found the arrangements in place for people who had monies managed by the service needed to be improved to protect people from financial abuse.

We saw the service's recruitment procedures needed to be more robust to ensure people were cared for by staff who had been assessed as safe to work with people.

We did not receive any concerns from people or staff about the staffing levels at the service. However, a few people living at the service had complex needs and restricted mobility. The service only provided a staff sleep in service at night, which meant people's wellbeing was not checked during the night. Neither did the service have a call bell system in place so that those people could summon for assistance if required. The registered manager told us they would provide people with restricted mobility with a wireless bell in their room so they could call for assistance from staff. During the inspection we saw the staffing levels in place could not ensure the people with poor mobility were supervised and monitored to an adequate level to ensure they were safe.

Medicines were managed safely at the service. However, we saw the storage of medicines required improvement to ensure they were stored appropriately and within a safe temperature range.

People had individual risk assessments for such things as deterioration in skin condition. We saw that some people's risk assessments would benefit from being more detailed on the measures being taken to reduce their risk.

The service had a process in place for staff to record accidents and untoward occurrences. The registered manager told us the occurrences were monitored to identify any trends and prevent recurrences where possible.

People we spoke with told us they were satisfied with the quality of care they had received. Some people living at the service communicated with us by using signs and gestures to confirm they were satisfied with the care they had been provided. However, our findings during the inspection showed some of the routines at the inspection did not uphold people's dignity and did not respect their human rights. For example, the routine of telling people they had to go to their room when medication was being administered. The registered manager told us this medication routine would be stopped.

We received mixed views from people about staff working at the service. People's comments included, "Most of the staff are alright, they look after me," "I get on with most staff," "One staff member is less friendly than the others" and "The staff are great, you can have a real laugh with them and they care for us so well."

We saw there was a lack of understanding at the service in regards to supporting people's autonomy and

independence in all aspects of their care and that people needed to be supported to the maximum extent. We saw people could be supported to be more involved in their community and have goals and aspirations. People could be supported to have more control over their monies.

People we spoke with made positive comments about the quality of the food provided and told us their preference and dietary needs were accommodated.

The service had not ensured staff had undertaken training which was regularly updated to ensure they had the skills and knowledge to support people effectively. For example, some staff required their first aid training to be updated. We saw staff had not undertaken any training about supporting people with learning disabilities.

The registered manager had recently reviewed people's care plans. The care records showed people were provided with support from a range of health professionals to maintain their health. We saw the service had a good working relationship with the local GP and district nurses.

We saw the activities provided could be improved for people so they were provided with a range of leisure opportunities in the service and within the community.

The service had not received any complaints since the last inspection. People we spoke with felt if they had any concerns or complaints they would be listened to. However, we saw that people would benefit from being invited to express their views about the care and support in a range of accessible ways.

In our discussions with the registered manager we saw they cared about the people living at the service and had developed a trusting relationship with them. However, we found the culture of the service did not always question some of the practices at the service and the leadership did not drive improvement.

We found some of the quality assurance procedures in place to cover all aspects of the running of the service required improvement.

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.

We found the premises and equipment were not clean or properly maintained.

People were not protected from the risk of financial abuse.

Recruitment procedures needed to be more robust.

Medicines were not stored appropriately and at the right temperature.

We saw the staffing levels at the service required improvement to ensure people with complex needs and poor mobility received appropriate care.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not completed all the necessary training and the systems in place to ensure their training was regularly updated required improvement.

During the inspection we saw some of the practices at the service did not support people to have maximum choice and control over their lives.

We saw the service monitored people's health needs and acted on any issues identified.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect, and their privacy was protected.

We received mixed views from people about the staff working at the service.

We saw people's autonomy and independence was not supported to the maximum extent.

The relative we spoke with made positive comments about the staff working at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw the activities provided could be improved for people so they were provided with a range of leisure opportunities in the service and within the community.

The service's complaints process required updating. People told us they would speak with staff if they had any concerns. However, we saw that people would benefit from being invited to express their views about the care and support in a range of accessible ways.

People's care records showed that people had a written plan in place with details of their planned care.

Is the service well-led?

Inadequate

The service was not always well led.

People and relatives we spoke with made positive comments about the registered manager. However, we saw the culture in the service needed to be changed to ensure people were appropriately supported.

The processes in place to ensure the quality and safety of the service were ineffective in practice.

We saw the views of people and their relatives could be more actively sought to continuously improve the service.

Orchard 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.

This inspection took place on 24 and 30 January 2018. The first day of the inspection was unannounced, which meant no one knew we would be visiting the service. The second day was announced to ensure the registered manager and provider were available to speak with. The membership of the inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example, where a person who uses the service experiences a serious injury.

We gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was reviewed and used to assist with our inspection.

Before the inspection, the provider had not been asked to complete a Provider Information Return (PIR) due to the rescheduling of the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with nine people living at the service, one relative, the registered manager, the registered provider (the owner), a team leader, a senior support worker and a care staff member. We looked round different areas of the service; the communal areas, bathroom, toilets, and some people's bedrooms. We reviewed a range of records including, three people's care records, three staff files, medication administration records,

incident records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt "safe" and had no worries or concerns. Comments included, "I do feel safe here" and "This is a grand place, you couldn't be safer anywhere else," "We talk about the fire drills at all our meetings" and "We do quizzes and questions about if we have a fire." People we spoke with were really clear that they would speak to someone if they were worried or had any concerns. The relative we spoke with felt their family member was 'safe'. They said, "I am so grateful that my [family member] is here, they [staff] absolutely keep [family member] safe."

We checked to see if there were sufficient numbers of staff to keep people safe and meet their needs. All the people and the relative we spoke with did not express any concerns about the staffing levels at the service. The registered manager told us there was a minimum of two care staff who worked at the service during the day. At night there was one member of staff who slept in at the service. We saw two people living at the service had complex needs and poor mobility. We saw the staffing levels in place could not ensure these two people were supervised and monitored to an adequate level. For example, we observed one person using their zimmer frame to move slowly along the corridor, but they were not being monitored or supervised by staff. When we spoke with them they described how they were at risk of falling and had fallen. They also needed support with all aspects of their personal care. We asked them how they asked for assistance from staff as they did not have a call bell to use in their room. They told us they just shouted, but described how staff didn't always hear them so they just gave up.

The service did not have a built in call bell system except for a bell on a corridor on the first floor for people to summon assistance if required. In addition, because staff 'slept' at night and there was no system for people to summon assistance. The staff slept in a bedroom on the top floor. The two people who had reduced mobility were located on the ground floor so it would be difficult for them particularly at night to obtain assistance. For example, if they needed support to go to the toilet or were experiencing pain. The registered manager told us a wireless bell would be provided to the two people so they could call for assistance when they needed it during the day or night. They assured us regular checks would be undertaken to check to ensure this wireless bell was in reach and available for them to use.

During the inspection we also found the cleanliness of the service required improvement. This showed that the number of staff hours dedicated to keeping and maintaining the cleanliness of the service required improvement.

This was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We looked at the procedures for recruiting staff. We checked three staff recruitment records. In one staff file we saw there was no record to show a Disclosure and Barring Safeguarding Check (DBS) had been completed. A DBS check provides information about any criminal convictions a person may have. This helps to ensure people employed are of good character and have been assessed as suitable to work at the service. There was no record that a reference had been obtained for the staff member whilst they were

employed at a care service. The registered manager told us they had obtained a verbal reference from the staff member's previous employer and it had been satisfactory. The registered manager and provider told us they would make the appropriate checks prior to the staff member returning to work. The staff member would be on leave with pay. This showed recruitment procedures in place to help keep people safe required improvement.

We saw the a recruitment policy was in place, but it did not identify all the information as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which must be available to demonstrate fit and proper persons have been employed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

We noticed that some staff had been working at the service for a significant amount of time with no further DBS checks recorded. We recommend the registered provider considers requesting staff to complete an annual self-declaration relating to criminal convictions incurred since their previous criminal record check.

We checked to see if people were protected from abuse and avoidable harm. We saw information about how to report safeguarding concerns was displayed in the staff room. The registered manager and the senior care staff were aware of the reporting procedures to follow. The registered manager told us they had not reported any concerns to the local safeguarding authority. They told us they would access the local safeguarding protocols via the internet if they needed to report any concerns. We saw the service would benefit from having a hard copy of the local safeguarding protocols available for staff to refer to, so that the information was more readily available. We shared this information with the registered manager.

At the time of the inspection there were eleven staff including the registered manager working at the service. We looked at the service's training matrix. This showed six staff had not completed safeguarding vulnerable adults training since 2015. It is important that all staff safeguarding training is regularly updated so staff have a good understanding of their responsibilities to protect people from harm. The registered manager told us they were liaising with the local authority about providing staff training.

During the inspection we checked a sample of people's financial records. We saw the system in place required improvement. For example, we saw transactions were not always signed by both the member of staff and person who used the service. If a person is unable to sign or doesn't want to sign a second signature should be sought from another staff member or other suitable witness, such as a visiting relative, to minimise the risk of financial abuse. We also found it difficult to find out what some of people's monies had been used for as this had not always been recorded. We saw the auditing of people's financial records needed to be more systematic and robust. We saw people's financial records had not been included in any independent audit of financial records undertaken on behalf of the registered provider. We also found the service's managing monies policies and procedures needed to be reviewed, so that it reflected the current procedures in place to manage people's monies at the service. We also saw staff required further written guidance to ensure they supported people appropriately with their monies. During the inspection we found that two people had been charged for purchasing a chair for themselves. The registered provider's statement of purpose states the cost of any furniture is included in the fees. The registered provider and manager assured us improvements would be made.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

On our arrival we noticed the service's certificate of employers liability insurance had expired. We spoke with the registered provider who contacted the service's insurers to obtain a new certificate. A copy of this certificate was provided on the second day of the inspection.

On the first day of the inspection we checked the safety of the building and noticed some of the fire doors at the service had been wedged open. This meant doors meant to protect people in the event of a fire would be unable to do so. We informed the registered provider. On the second day of the inspection we noticed doors were not being wedged open, but the change had upset some people who used the service. The registered provider told us they were looking at fitting doors that were self-closing when a fire occurred, which meant doors could remain open and would close in the event of a fire. There showed there had been routine disregard of fire safety procedures.

The registered provider provided evidence to show that fire drills had been carried out on a regular basis and fire equipment checked. However, the fire officer had inspected the service in November 2017 and found a number of concerns which they had asked the registered provider to do to improve fire safety. These actions included: The fire safety order stated the service's fire risk assessment was not suitable and sufficient. The service's emergency procedure needed to be reviewed to clearly explain the procedure and actions to be taken by staff. The means of escape should be available without the use of a key. Emergency lighting throughout the premises to be assessed to ensure adequate levels of illumination. Ensure all fire doors were in good repair. The fire officer had noted some door did not fully close onto their rebates. Holes within the premises should be fire stopped. At the time of the inspection we saw the progress of complying with the order needed to be improved and action taken to fully comply with the order. The registered provider told us they were going to employ an external company to review the service's fire risk assessment and arrange for the work to be completed. They also assured us action would be taken promptly to comply with the order.

We found the service's legionella risk assessment needed to be more detailed. The HSE Health and safety in care homes states the following: a competent person, who understands the water systems and any equipment associated with it, should assess the risks of your hot and cold water systems, and advise on whether adequate measures are in place to control the risk of exposure to legionella bacteria.

The service had not been properly maintained. The decoration and flooring was poor in areas of the service. Some of the furniture was worn in the lounge area and needed replacing. The lock on one of the laundries was missing. The fittings and flooring in bathrooms and ensuites we looked at all required some maintenance including the removal of mould and/or renewal. For example, the flooring in one of the bathrooms was not fitted and we saw ripples, which presented a tripping hazard. There was a gap between the lino and the skirting board, which meant ill-fitting flooring, which could not be kept appropriately clean. The water pipes had not been boarded up, which presented a risk of injury to people. The bath was stained and the sealant around the bath was cracked and had mould.

We checked to see if people were protected by the prevention and control of infection. The service did not employ any domestic staff. It was part of the support worker's duties to complete cleaning tasks. We saw there was hand sanitiser available in different areas of the service and hand washing information in bathrooms. We saw the service had a system in place to manage any soiled laundry. However, we saw the cleanliness of the service required improvement. The bathroom and toilet areas we looked at needed to be cleaner. For example, the floor covering was loose in one bathroom and the flooring below was stained with urine. One person's room did not smell clean and their carpet was heavily stained. It is important that people have a clean and pleasant environment to live in. On the first day of the inspection we also saw staff had not handled soiled pads appropriately and placed them in a waste paper bin. It is important that staff

dispose of clinical waste correctly. The registered manager told us they had spoken with the staff member concerned. We saw staff were using colour coded cleaning equipment to reduce cross infection, but we saw this equipment was not always being stored correctly to minimise the cross infection. During the inspection we also saw some of the bedding and towels were tired and worn and would benefit from being replaced.

We saw the registered manager had a process in place for staff to record accidents and untoward occurrences. The registered manager told us they regularly monitored the occurrences to identify any trends and prevent recurrences where possible. However, this had not always been effective. The incident records showed one person had fallen from the top step at the front of the building in November 2017, but no action had been taken to review or improve the access to the building, nor identified the building required improvement to meet the needs of disabled people. If disabled access had been in place at the front of the building this would have reduced the risk of the person falling.

We found the systems and processes in place did not assess or properly manage environmental and equipment related risks. Our findings showed the premises and equipment used by the service provider had not been kept clean, properly maintained and suitable for the purpose for which they are being used.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises.

We checked whether people's medicines were managed so they received them safely. People we spoke with told us they received their medication regularly and on time. We reviewed a sample of people's medication administration records and medication. We saw medicines were stored in a filing cabinet in the staff room. We saw the temperatures for storing medicines were monitored for the room and the fridge. We saw staff had recorded repeatedly that the temperature had exceeded 25 degrees centigrade and no action had been taken to reduce the temperature, so that medicines were stored at an appropriate temperature. No medicines were being stored in the fridge, but we saw the temperature of the fridge exceeded the recommended limit. On the second day of the inspection the registered manager told us they had contacted the local pharmacist. The pharmacist was helping them to find suitable storage and putting measures in place to reduce the temperatures to a safe level.

Medicines that are controlled drugs (CDs) were kept in cupboards that complied with the law. This meant that medicines could not be mishandled or misused by other people, and that they were safe to use.

People had individual risk assessments in their care plans. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. We saw that some people's risk assessments would benefit from being more detailed on the measures being taken to reduce their risk. For example, full details of the action being taken to reduce and manage the risks of the person developing a pressure sore.

Staff we spoke with told us some people living at the service displayed behaviours as a means to communicate their feelings or as a way to request support. Staff told us they knew people really well at the service and were able to recognise when a person was being unsettled or distressed. Staff were able to describe the different strategies they used to support the person to become more settled and promote wellbeing.

Requires Improvement

Is the service effective?

Our findings

During the inspection we found the systems in place to ensure staff received appropriate training to enable them to maintain their skills and improve their knowledge required improvement. The service's staff training matrix showed that all the staff had not been provided with all the recommended or minimum learning and development for staff working in social care. For example, equality and diversity training. We also saw that the staff had not been provided with refresher training in some areas at the recommended frequency. For example, annual safeguarding vulnerable adults training.

The staff training matrix also showed that six staff had not completed infection control training since 2015 and four staff since 2016. Our findings during the inspection showed that staff would benefit from receiving refresher infection control training.

During the inspection we provided the registered provider and manager with a copy of the information provided on the Skills for Care website about the recommended frequency of refresher training. Skills for Care is the strategic body for workforce development in adult social care in England. We also saw staff had not completed training in supporting people with learning disabilities and/or autistic spectrum.

This was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Staff we spoke with told us they felt supported. We saw that staff received regular one to one sessions to discuss their performance. Staff had received an annual appraisal. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. The registered manager told us they were intending to change the documentation used for staff appraisals so it included a discussion about goals and objectives. The staff member would also be asked to record how well they thought they had performed.

We saw two people using the service had restricted access to the outside of the building because they needed a wheelchair to leave and enter the building. One person said, "The staff hold the wheelchair in the street and I turn myself to get in it." This also presents a risk of accident and injury to both the person and staff because the action is not a safe moving and handling practice.

We found the premises would be challenging for people who had poor or decreasing mobility. The service had several steep stairways up to the first floor and the floors were not all on a level. For example, on the ground floor people had to step down to use one of the bathrooms or access one of the lounges. The registered manager confirmed the ensuite shower rooms were not suitable for the two people who had poor mobility to use. These people were offered a shower whilst they sat on a bath seat board. We did not see plans in place to show that consideration had been given to how people would like to be supported and whether any aids or adaptations were needed to improve access to appropriate bathing facilities.

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. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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 Mental Capacity Act. 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.

The registered manager was aware of the need to submit applications for people to assess and authorise that any restrictions in place were in the best interests of the person. The registered manager told us there was nobody living at the service who required a DoLS authorisation.

During the inspection we saw some of the practices at the service did not support people to have maximum choice and control over their lives. For example, we saw people were asked to wait in their room whilst medication was being administered by staff. This included people who did not require any medication. We found one person sat in the dark in their room waiting for medication. This was an unnecessary control to enable people to receive their medication. We spoke with the registered manager; they assured us this practice would be stopped.

We also saw that people had not been consulted about the use of CCTV in some of the communal areas and their consent for its use had not been obtained. For example, the two lounge areas had CCTV installed. If any form of surveillance is used for any purpose, providers must make sure this is in the best interest of people using the service. Any surveillance should be operated in line with current guidance. We shared this feedback with the registered manager and provider and provided a copy of CQC's CCTV guidance.

This was a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

People we spoke with did not share any concerns about the care they had been provided. The relative we spoke with was satisfied with the quality of care their family member had received. They said, "Me and my family can rest assured [family member] is well cared for" and "[Family member] couldn't receive better care." However, our findings during the inspection showed the care and support provided by staff at the service did not always reflect current best practice. For example, people being told to go their room when medication was being administered.

The service had developed strong links with the local GP and other external healthcare professionals to promote people's wellbeing. We saw the service monitored people's health needs and acted on any issues identified. We saw a range of external healthcare providers had been involved in people's care including district nurses, community learning disability nurses, GPs, opticians, chiropodists and dentists.

We saw people enjoying the food that had been provided. We saw that the main meal of the day was prepared in the service each day and on the first day of our visit this meal looked wholesome and smelled really appetising. People told us or indicated with gestures that they were looking forward to eating it. Comments included, "The food is alright," "The dinner smells lovely, I can't wait," "The girls [staff] are good at cooking," "I can have anything I like to eat" and "I like all the food they give us." The relative we spoke with was satisfied with the quality of food provided at the service.

We asked staff how people were given choices in regards to their meals. Staff told us they planned the menu

taking into account what they knew about people's preferences. They told us that for people who were unable to express their choice verbally they used familiar gestures to be certain they wanted that meal. This ensured people were offered food that they enjoyed. The staff were seen trying to be calm and patient when encouraging people to the dining tables. Some people were repeatedly leaving the dining area and staff calmly supported them to return to the dining area.

Requires Improvement

Is the service caring?

Our findings

We found the service was not always caring. On the first day of the inspection we saw staff activities were centred around completing tasks. On the second day of the visit we saw more examples of the support staff actively sitting with people and chatting. Observations showed that staff treated people kindly, but not always with respect. For example, we saw staff did not always knock on doors or call out before they entered people's bedrooms. Staff did apologise when they entered to find a member of the inspection team speaking with people.

Our findings during the inspection showed some of the routines at the service did not uphold people's dignity and did not respect their human rights. For example, the routine of telling people they had to go to their room when medication was being administered. We saw there was a lack of understanding in regard to supporting people's autonomy and independence in all aspects of their care and that people needed to be supported to the maximum extent. For example, we saw the service did not actively work with people to increase their involvement in their local community. We saw people could be supported to have more goals and aspirations.

Resident meetings are an avenue to obtain people's views about the service and how the service can improve together with support from the registered provider and manager. The meeting records showed there had been discussions about road and fire safety. However, the records showed that people's dignity was not always upheld and contained some sensitive issues, which were personal and not suitable to be discussed at open forums. For example, staff had recorded the following, "Some residents are having issues, and this is causing a lot of washing and drying. If anybody needs advice on bowel movement care please see [staff member name]." In another meeting staff had discussed the condition a bathroom had been left in as faeces had been smeared on the wall. We discussed this example with the registered manager and they agreed this should not have been discussed at the meeting and did not uphold people's dignity. This should have been discussed with people on a one to one basis.

Staff had also told people that only one person was allowed to come up to the counter when they were giving out money. People have a right to access their own monies when they want to; the service's role was to provide a safe place to store their monies. We noticed that none of people living at the service had been provided with the choice to store their own monies in a locked cupboard in their rooms. We also found some people had minimal knowledge of the amount of monies they had in savings. This knowledge helps empower people to make decisions about how they wish to use their monies. For example, to go on trips.

We had a discussion with the registered manager about staff including judgement statements in one person's care plan which was inappropriate. For example, judging the person had a selfish nature because of some of the behaviour they displayed.

During the inspection we observed some positive interactions between staff and people. We observed staff worked patiently with people, trying to help people understand questions and make choices. We observed staff using their knowledge of the person, and their experience of what different words and gestures meant

to help people make choices and express their wishes. For example, we saw one person using signs and gestures to arrange a visit to the barbers shop. Another staff member described how a person would choose between items shown to them by pushing away the unwanted one.

We saw some of the staff and people looked comfortable together, there was some laughter between people. People we spoke with told us they got on well with "most staff". One staff member was described as less friendly than others. People's comments included, "Most of the staff are alright, they look after me," "I get on with most staff," "One staff member is less friendly than the others" and "The staff are great, you can have a real laugh with them and they care for us so well." The relative we spoke with also made positive comments about the staff. They said, "Staff have such devotion to my [family member]" and "I come on different days, so I get a good idea of what's going on, some of the staff are great."

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us staff tried to plan their preferred activities. On the first day of the visit the staff organised an impromptu game of bingo. One person was supported to go to the library by a staff member. The person showed us the books they had read and were returning to the library. They said, "I get to go to the library. I am really interested in history at the moment." Some people living at the service attended a day centre during the week. One person told us they could choose to go on trips arranged by the day centre if they were available. For example, they told us about a film they had recently seen. People told us they had really enjoyed a Halloween Party held a few months ago at the service. One person said, "We had a great Halloween party, it was great." One person told us they went to a church service regularly and how important it was to them. However, we saw some people did not go out on trips very often. People's comments included, "I've have not been on an outing for ages" and "I would happily pay extra to go out on trips."

The relative we spoke with told us staff did try to involve their family member in activities and asked them for any suggestions, but their family member couldn't really get out now as they needed to use a wheelchair. Two people living at the service had complex needs and poor mobility. We saw these people were spending more time in their bedrooms so they were not engaging or communicating with other people as they had in the past. The staff we spoke with did not consistently recognise that these two people did not partake in the lifestyle and activities chosen by the majority. Both of these people said that they would like to go on outings if possible. We saw that these two people were at risk of social isolation.

The registered manager told us the service had not received any complaints since the last inspection. We noticed the service's complaints processes required updating so it included details of the Local Government Ombudsman. The Local Government Ombudsman, consider complaints about the provision of both health and social care funded by the NHS or local councils in England. People and their relatives told us they knew how to complain and they told us they would inform staff if they were unhappy with their care. People's comments included, "I always say it like it is. I would say if I wasn't happy" and "I would tell the staff if anything was wrong." However, we noted that people we spoke with did not know about any leaflets or documents explaining their right to make comments about the care and support they received. We saw that people would benefit from being invited to express their views about the care and support in a range of accessible ways.

The service had a staff on call rota. Staff were able to ring the staff member on call and ask for advice or ask for an additional staff member to come to the service. For example, if a person had become unwell and needed to be escorted to hospital. The service had guidance in place to follow if there were emergency procedures. This included, missing person, accident and incidents procedures. We saw the guidance for accidents included, 'check the importance of the injuries and deal with worse first'. The service's staff training matrix showed that five members of staff had not completed first aid and life support training since 2015 and one member of staff since 2016. It is important that staff first aid training is annually renewed to ensure they maintain their knowledge and skills to ensure they respond appropriately.

Staff spoken with had a good knowledge of people's individual health and personal care needs and could clearly describe the history and preferences of the people they supported. The registered manager told us the service had recently reviewed people's care plans. People's care records showed that people had a written plan in place with details of their planned care. We noted that one person did not have a catheter care plan in place. We also noticed one person's eating and drinking care plan required updating to reflect the current care being given. We shared this information with the registered manager who said a plan would be completed.

The relative we spoke with told us staff kept them informed about their family member's wellbeing and their family member saw the GP, optician and district nurse when they needed to. The registered manager told us the service had a good working relationship with the local GP. People also told us they saw the doctor when they were not feeling well.

During the inspection we saw the service would benefit from reviewing whether people living at the service would benefit from information being provided so that it was more accessible. The accessible information standard says that people who have a disability or sensory loss should get information in a way they can access and understand.

The registered manager told us nobody was receiving end of life care support at the service. They told us people's preference at their time of death had been discussed and noted in their care plan. For example, preferred funeral arrangements.

Inadequate

Is the service well-led?

Our findings

In our discussions with the registered manager we saw they cared about the people living at the service and had developed a trusting relationship with them. All the people we spoke with made positive comments about the registered manager and knew them well. People's comments included, "I get on really well with [registered manager] and [registered provider], they are great." "The manager is very nice, but I don't see much of her" and ""The manager is smashing, she is so friendly." We also received positive comments from the relative we spoke with. However, we found the culture of the service had not always questioned some of the practices at the service and the leadership had not driven improvement in current best practice of care delivery, which had impacted. Our findings during the inspection showed some of the routines at the service did not uphold people's dignity and did not respect their human rights. We saw there was a lack of understanding in regard to supporting people's autonomy and independence in all aspects of their care and that people needed to be supported to the maximum extent. The culture of a service directly impacts on the quality of care a person receives.

The service did not hold meetings with relatives. We saw the systems in place did not actively seek the views of people's relatives and representatives to continuously improve the service. The service held regular resident meetings. However, the meeting records showed that people's dignity was not always upheld and contained some sensitive issues, which were not suitable to be discussed at open forums.

All the staff we spoke with made positive comments about the management of the service and that there was a good team working at the service. Some of the staff we spoke with told us they had obtained further qualifications whilst working at the service. However, we saw the registered manager had not ensured staff working at the service received appropriate training that is necessary to enable them to carry out their duties. The service's staff training matrix showed none of the staff working at the service had completed any training for supporting people with learning disabilities. It is important that staff receive appropriate training to meet the needs of the people they are supporting.

We saw the arrangements in place to ensure policies and procedures were reviewed regularly to ensure the service met current legislation required improvement. We saw the registered provider and manager were not always aware of or confident about current best practice or the requirements of the law. During the inspection we provided information that was available on the CQC website for providers and Skills for Care website to the registered manager and provider. This meant the leadership at the service was reactive rather than proactive.

We found the quality assurance processes in the service were ineffective in practice. For example, a regular medication audit was completed at the service. Concerns were found about staff not always signing the person's medication administration record, but there was no follow up action recorded. The system in place to check the service was kept clean required improvement.

During the inspection we saw the premises were not clean or appropriately maintained. The registered provider was responsible for the maintenance of the service. This showed the system in place to ensure the

service was appropriately maintained was ineffective in practice.

This was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. During the inspection we checked to see if CQC was being notified appropriately and did not find any concerns.

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 The provider had not ensured service users were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that service users were protected from abuse and improper treatment in accordance with this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that fit and proper persons were employed at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff deployed to ensure people were safe. The provider had not ensured staff received appropriate training to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises and equipment were clean, properly used, properly maintained and suitable for the purpose for which they are being used.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services.

The enforcement action we took:

Warning notice