Integra Care Homes Limited

Integra Care Homes Limited - 105 Water Lane

Inspection report

105 Water Lane
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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service

105 Water Lane is a residential care home providing accommodation and personal care to older and younger adults with a learning disability or autism. At the time of the inspection there were four people living at 105 Water Lane, some with complex needs. The service can support up to eight people.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to eight people. Four people were using the service. This is larger than current best practice guidance. However. the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found

People were not safe from potential harm because known risks to people were not effectively being monitored by the management and staff team. People who had known risks of ingestion, and where incidents had already occurred, still had access to items that could cause them potential harm.

There were inadequate numbers of permanent staff and the service was reliant on agency staff.
There were not sufficient staff with suitable skills, knowledge and experience deployed to meet the needs of the people.

Relevant recruitment checks were conducted before staff started working at the service to make sure staff were of good character and had the necessary skills. However, there were unexplained gaps in staff employment histories.

Environmental risks were not managed effectively; fire alarm tests were not up to date as recommend by fire safety regulations. People did not have regular fire evacuations to keep them safe. The home was dirty and in need of cleaning and the service needed redecoration.

People were not supported to eat a balanced diet. There were not meaningful activities and access to the community for people to reduce the risk of social isolation. People were not always treated with dignity and respect.

Medicines were not always safe, and people did not have pain relief available to them when needed.

Staff did not receive regular support and one to one sessions or supervision to discuss areas of development and to enable them to carry out their roles effectively. Training had fallen behind, and we could not be assured staff had appropriate training in place to keep people safe.

People's rights were not always protected because staff did not always understand and work within the principles of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. These were in the process of being reviewed.

Each person had care plans in place although there was not always sufficient detail to guide staff and plans were not always up to date. We found staff did not always follow the guidance and some plans contained inaccuracies and missing information. There were concerns with missing entries and gaps in charts to monitor people's food and fluid and bowel movement.

During our inspection we found there was a lack of effective management and leadership in the home. Staff felt unsupported and let down by management and morale was low amongst staff.

The provider had failed to ensure effective oversight of service provision. Care plans were not consistently person centred and lacked detailed guidance for staff to ensure people received care in a person centred and safe way.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 23 February 2019).

Why we inspected

The inspection was prompted due to concerns received about staffing, accidents and incidents, management oversight, medicines, support plans, records and the maintenance of the building. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see information in the report.

Enforcement

We have identified breaches in relation to safe care and treatment, staffing, person centred care, dignity and respect, meeting nutritional and hydration needs, premises and equipment and good governance at this inspection.

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.

Follow up

We would normally follow up as per the guidance below but the provider following receipt of the report has decided to close the service.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Integra Care Homes Limited - 105 Water Lane

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by two inspectors.

Service and service type

105 Water Lane 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 service did not have a manager registered with the Care Quality Commission. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection which included

concerns we had received. We sought feedback from the local authority and spoke to four professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We observed care and support during the inspection by staff around the home. We spoke with three relatives about their experience of the care provided.

We spoke with twelve members of staff including the regional director, regional quality manager, the provider's specialist support practitioner, interim managers, shift leaders, support staff and agency staff.

We reviewed a range of records. This included four people's care records and medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Health professionals we spoke with felt the service didn't manage risks well. One health professional said, "Recent safeguarding concerns have highlighted concerns with how the service manages risks. The team have highlighted concerns about staff ability to support certain individuals in the community and provide positive and proactive risk assessment."
- People had individual risk assessments that identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. However, these were not always followed by staff to keep people safe. For one person they had Pica like tendencies which meant they were at risk of eating objects that were harmful to them and as a result were a high risk of choking. Records showed that a choking risk assessment had been completed in March 2019 where no choking risk had been identified.
- In April 2019 they had an incident where they had indigested a non-food substance which put them at serious risk of harm and medical assistance was sought. Following this incident their choking risk assessment had not been updated and on day two of our inspection we observed harmful objects in their room. We informed staff, and these were immediately removed.
- Their support plan advised staff that no control of substances hazardous to health COSHH items should ever be left out in their presence or any items that they could swallow and following the choking incident environment checks had been implemented. However, these were not always completed. For example, in August 2019 records showed these had only been completed on seven days during August with the last completed record on the 25 August 2019. We saw no records completed for September 2019.
- On the second day of our inspection we observed the laundry room unlocked with various COSHH items on display which was next to the person's room and was easily accessible to them. Again, these were immediately removed. We asked staff why the door was not locked and were advised that the key had been lost, and that COSHH items were meant to be stored upstairs in a locked COSHH cupboard. The interim manager told us the lock had broken and they were awaiting a new lock for the laundry and have moved all COSHH items back upstairs.
- We were concerned about the safety of this person and made a safeguarding referral to the local authority. We also asked the provider to assure us how they were going to keep the person safe. However, a visit from the local authority following the inspection showed items that put them at risk were still left in their room. The provider informed us they have now implemented hourly checks and were monitoring the person's safety.

The risks associated with people's care had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014; Safe care and treatment.

● Suitable checks were not always made to ensure the building was safe. Weekly and monthly fire checks were not always carried out to ensure people were kept safe. Records showed the last weekly fire tests were completed on the 13 July 2019 as well as the monthly fire checks including emergency lighting. Guidance issued on fire safety for care homes states, 'test fire detection and warning systems weekly following the manufacturer's or installer's instructions.'

● A designated fire escape door was hard to open. Staff told us they have had problems with the lock and maintenance have been out to repair it. However, it still got stuck and we were told they would investigate our concerns.

● Individual personal emergency evacuation plans (PEEPs) were in place to guide staff in how to keep people safe during an evacuation. However, not all staff seemed aware of people's evacuation plans and one staff member told us they would re-enter the building to go through the garden to the designated fire assembly point rather than round the side of the house. This could potentially put someone at great risk as you should never re-enter a building in the case of a fire.

● The provider had a fire risk assessment in place which stated that four full fire evacuations should take place annually. Records showed that two fire evacuations had taken place during 2018 and no records had been completed for 2019 to show these had taken place. For one person they had been set a goal of completing a full fire evacuation once a month, so they were aware what action to take in the event of a fire. We saw a progress form to monitor their process. However, records showed this was not completed and no information to support this progress was happening. Training records showed that some staff were out of date for fire training. The provider had not ensured that staff would be competent in the event of an emergency evacuation.

● Other health and safety checks including water had stopped taking place. The provider could not evidence that electrical and gas safety checks had been completed. There were not effective systems in place to identify maintenance issues in the home or when these were addressed.

● The service did not have a business continuity plan in place to describe how people would continue to receive a service despite unfortunate events and emergencies. The interim manager told us they were going back to basics and starting again and had a template ready to put one in place.

The failure of the provider to ensure that the risk to people was minimised in the event of an emergency or evacuation meant that people had been put at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Staffing and recruitment

● The provider was using a high proportion of agency staff to cover staff vacancies. For example, on the first day of our inspection there were a total of four support staff on shift and one team leader supporting people. The team leader was a permanent member of staff and the rest of the staff were all agency staff, except for a member of staff returning from long term leave who was shadowing staff and not included in the shift numbers. This was also the same on the day two of the inspection. On the third day three members of agency staff were on duty. A relative told us, "My concerns are that they seem to have a very high turnover of staff which is not good for someone with autism as they need to have regular staff to build the relationship up with." A health professional told us, "Due to the level of agency staff being used and number of hours staff are working, there are concerns about the effects of this will have on a delivery of a safe service." Another health professional said, "The provider seems to struggle to retain and recruit the staff."

● Although there were enough staff to support people, agency staff did not always have the necessary experience or training to support people safely. The provider obtained staff profiles for agency staff to check they had appropriate training and recruitment checks in place to keep people safe. However, we could not find profiles for all the agency staff working and some profiles showed that agency staff did not always have

the appropriate training to support people safely or that they were safe to work at the service.

Failure to make sure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to support people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most recruitment processes for permanent staff were followed that meant they were checked for suitability before being employed by the service. Staff records included an application form, two written references and a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, some records did not contain a full employment history. For one person this had been followed up by the provider in April 2019 for the staff member to explain gaps in employment, but records did not show the information had been received and updated.
● At the time of our inspection we did not have full access to all recruitment files as some staff member files were in other service locations and not on site.

Using medicines safely
● Medicines were not always managed safely. For example, one person had continued to receive the wrong dose of a medicine after their GP had reduced it. A health professional told us, "In the past we have had concerns regarding the medication of a service user, and after contacting the GP had significantly reduced his medication. This would not have been picked up without our involvement".
● There was no clear guidance for staff as to when to give PRN 'as required' medicines for pain relief. This had resulted in two people having no pain medicine in stock. One person had no pain relief medicine since April 2019 and the other person no pain relief medicine since July 2019. This meant PRN systems were not clear and people might be in pain and not be able to receive effective relief as no medicines were in stock to support them to manage their pain.
● Medicines were not always put back in the original packaging. We checked one person's medicines and the original box said it contained 30 tablets and when we checked it contained 40 tablets. The expiry date on the box was 10/2020, however the expiry dates on the blister packs inside did not match the box with one due to expire at the end of September 2019, and it was not included on the monthly medicines returns for this month.

Failure to ensure the safe and proper management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

● Staff had received training for the safe handling of medicines. Records showed that staff had received an assessment of their competency to administer medicines in line with best practice guidance. However, this had not always been effective as good practice had not always been followed.
● There were appropriate arrangements in place for the recording and administering of prescribed medicines and medicine administration records (MARs) confirmed people had received their medicines as prescribed.

Preventing and controlling infection
● Infection control practices were not always safe. Some areas of the home were visibly dirty, especially people's shower floors and basins.
● Some parts of the home were in need of a refurbishment and presented an infection control risk. In one-

person's ensuite shower room the hand basin had cracks which could harbour germs and one person's ensuite shower floor had some exposed areas. We were concerned that these areas could not been cleaned properly and hygienically. We saw one person's pillow was badly stained and people's beds and mattress looking very worn and in need of replacement.

● During the inspection, on day two, the staff toilet did not have any soap, hand gel or paper towels for staff to maintain hand hygiene. We informed a staff member during the morning, however later in the day there were still no hand washing equipment available. On the third day of inspection they were in place.

● We spoke with one of the directors who informed us that they had already agreed for a deep clean of the home before the inspection and this was scheduled for the 01 October 2019.

● All care homes are required to have an infection control lead in line with the Department of Health code of practice on the prevention and control of infections and related guidance. An infection control lead is someone with appropriate knowledge and skills to take responsibility for infection prevention and cleanliness. This meant there was also no annual statement to identify any issues or concerns. One of the interim managers informed us that they were in the process of identifying a staff member to take on this role.

Failure to ensure the premises are kept clean is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Premises and Equipment.

Learning lessons when things go wrong

● Records were maintained of accidents and incidents that had occurred. However, for one person we were concerned staff were not recording incidents or monitoring when they had self-injurious behaviour. Health professionals we spoke with all confirmed that staff were not recording or monitoring these concerns. One health professional said, "Recording of incidents and concerns seemed inconsistent and responses to incidents do not seem to be consistent". Another health professional said, "I have concerns regarding the wellbeing of the service users, with one particular service user engaging in concerning self-injurious behaviour for which the staff were not recording, monitoring or seeking support on".

● Staff not recording all accidents and incidents that occurred meant that they could not be reviewed, and any trends or patterns identified. This prevented any action being taken to reduce the risk of repeat incidents.

● On the first day of our inspection one person had an incident in the kitchen, as a staff member was asked to clear up the mess caused. However, we could not see any recordings of what had happened for their behaviour to escalate or details of the event.

Systems and processes to safeguard people from the risk of abuse

● Staff we spoke with had the knowledge and confidence to identify safeguarding concerns and told us they would act on these to keep people safe. However, we were concerned that staff had not had the skills and knowledge to identify the numerous concerns we found during our inspection as safeguarding issues. We made a safeguarding referral to the local authority following the inspection.

Failure to protect service users from abuse and improper treatment is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Safeguarding service users from abuse and improper treatment.

● Relatives we spoke with told us their loved ones were safe. One relative said, "It seems to be safe, [person] seems happy. If there is an incident like [person] pinches someone or if there is an incident, they contact me. Nothing has aroused suspicion".

● The service had recently had a break in and money had been taken from the provider's safe resulting in

people's money being taken. The provider was working with the police and an investigation was currently in place.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, supports and outcomes.

Staff support: induction, training, skills and experience

- People were not supported by staff who had completed or updated training. A relative told us, "The problem is the training of staff to work with people with autism and I feel that their staff need more training and be made aware of the behaviours people with severe autism have." One health professional told us, "The skills of the staff seem to vary, some staff seem to struggle with the basics needs and why some monitoring may be needed."
- The registered provider had a programme of induction and training in place. However, a record of all training showed that staff had not completed all relevant training and some had not fully completed their induction training.
- Training was not always effective to meet the needs of people living at the home. One person's care plan stated that staff are trained to administer first aid as they were at risk of choking. However, we could not be assured all staff had received this training, including agency staff.
- Some of the people the service supported might experience behaviours which may challenge others. Support plans showed staff need to be trained in positive behavioural support and PROACTSCIP®UK interventions. This supports staff to understand and recognise cues to behaviours through positive behaviour support. However, we could not see records that all staff had received this training as well as agency staff. We spoke with the provider's specialist support practitioner who has arranged workshops to support staff which will commence during October and will include regular agency staff. One of the interim managers told us they were going to start from starch and planned, mandatory training sessions would be in place for all staff.
- Records showed that staff had not been supported with regular one to one supervision meetings. We spoke with staff who told us they had not received supervisions for a long time
- Supervisions provide an opportunity to meet with staff, provide feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. The provider's policy stated staff should be supported on a minimum three-monthly supervision basis. Without these the provider cannot be assured staff have the right skills and support in place for them to effectively carry to their role.

The lack of effective supervision and training for staff meant we were not assured people received care from staff who had the right skills and competencies to meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Records showed that people were not supported to maintain a healthy diet. We looked at one person's nutrition records which showed most meals consisted of toast or burgers and chips. For another person chocolate was often consumed for a lunch time meal.

● The support plan for one person advised staff to support them make healthy choices, especially around their diet as given the choice they will always make unhealthy meal choices and need encouragement to try different foods. There was no evidence that they were encouraged to make healthy meal choices.

● One person's records showed that they were at risk of excessive drinking. However, records did not provide guidance for staff in how they should support this and how the person was at risk. Fluid charts were in place but were not always completed and did not contain information as to how much fluid was safe for the people to drink each day and what staff should do if they had concerns. Staff did not always add up the fluid intake each day. Therefore, it was not easy for staff to identify whether people had received enough to drink each day.

The lack of a variety of nutritious food was not available to meet peoples. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Health professionals we spoke with felt the service struggled to maintain good health of people living at the home. One health professional told us, "There are continuous concerns regarding their ability to monitor bowel movements, especially for individuals with limited food and fluid intake on stool loosening medication. There are also concerns regarding weight management. Staff were not recording weights for long periods of time, and on investigation it was discovered that one service user had lost a substantial amount of weight".

● Records showed that bowel charts were not always completed, and no guidance or protocols were in place to support staff on what signs to look for and to consider if the person may be constipated.

● Research and best practice show people with learning disabilities are at higher risk of having constipation as they may be unable to communicate this. It is essential for staff to be aware of the signs and symptoms of constipation as this can lead to health concerns and behaviour problems including self-harm.

● People were supported to access healthcare services when needed some of the time. Records showed people were seen regularly by doctors and chiropodists. However, a health professional told us, "Staff didn't seem to be concerned that [person's name] was unwell and health professionals chased them up for a doctor's appointment". Another health professional said, "Concerns have been raised about staff accurately monitoring individual's health and appropriately responding".

● A relative told us, "[Person] was supposed to go into hospital for dental treatment, there was a mix up and I wasn't contacted. I'm not always happy about the communication. Most of the time they are brilliant but there isn't someone there that knows what they are doing any more, at least not permanently anyway".

● For one person their care plan stated they had PRN medicine for anxiety before a visit for podiatry and they should take two tablets the night before the visit and three tablets on the day of the planned visit. On day two of our inspection the podiatrist visited the service and did not see the person, we were informed they were out, but they also were not given their medicines the night before in preparation for the visit.

● Information about people's health needs was included within their care files and health plans most of the time, including information as to what support people may need in relation to these. However, a health professional told us, "I do not have confidence in the support plans in place or the staff's ability in following the support plans".

People had a 'Hospital passport'. A hospital passport is a document providing information about a person's

health, medication, care and communication needs. It is taken to hospital if a person is admitted helping medical staff understand more about the person. However, these were found in the office and not with peoples care plans and not all staff were aware of them.

Failure to ensure people receive person-centred care and treatment that meets all of their needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Person-centred Care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● When people moved to the service, they and their families, where appropriate, were involved in assessing, planning and agreeing the care and support they received. However, we found the information was not always transferred into people's care plans to provide appropriate guidance for staff.

Adapting service, design, decoration to meet people's needs
● People had their own bedrooms and ensuite facilities and two people had their own lounge and dining areas. However, rooms were not personalised, and the layout was not best suited to the people living at the home. The provider was aware of this and had plans in place for re- decoration and improvements to the layout of the building.
● The garden area was also in need of improvement. There was a raised planter with a broken wooden panel. There was an activity hut at the back of the garden which had a splintered hand rail and a rusty nail sticking out which could cause harm.

Ensuring consent to care and treatment in line with law and guidance
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 (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● There was a risk that people's rights were not protected when they lacked mental capacity and when they were deprived of their liberty.
● The service recognised that they were depriving someone of their liberty by having to put restrictive measures in place to support one person. However, regular review of DoLS were not completed to ensure that measures in place were, and remained, the least restrictive.
● Some staff showed an understanding of the MCA. These staff were aware people were able to change their minds about care and had the right to refuse care at any point.
● Where people had been assessed as lacking the capacity to make decisions, these were not reviewed, and records seen were out of date.
● A health professional told us, "There was evidence of mental capacity being considered in certain areas and recorded in care plans, but the staff do not seem to always follow it up. Some staff also seem to lack knowledge around MCA 2005 and best interest principle".

Failure to protect service users from abuse and improper treatment is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Safeguarding service users from abuse and improper treatment.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. A relative told us, "I would like to see the service users' clothes are ironed and they are not made to look disabled when they go out. It is sad that they get a lot of money for looking after not only my son, but other service users and they cannot be bothered to do a simple task of ironing the service users clothes. The service users need dignity, and this is what lacks at Water Lane." Another relative said, "We just find [person's name unkempt all the time."
- There were previous concerns from the local authority that staff were using one person's flat as a thoroughfare to access the garden. We observed on many occasions staff still using the persons home to access the garden for smoke breaks. This showed no respect for the person and at times staff didn't even knock on their door to get permission before entering. The interim manager was surprised this was still happening on the first day of the inspection, but we saw this happening again on the final day of the inspection as it had become bad practice. This was not caring to the person and did not provide them with privacy. A health professional told us, "Some of the staff seem to have accepted practices that may have impacted on the service user's quality of life, e.g. walking through his accommodation to the garden, for staff breaks".
- One person had to move rooms due to a water leak in their previous room and were waiting for repairs. However, we noticed a social story on a communal wall of a person who lived in the room previously, which did not promote dignity or confidentiality. We handed this to one of the interim managers.
- The language used by some staff in writing up people's support records did not always show that people's dignity was respected. Records about people's behaviours were disrespectful and were not always written in a style appropriate for adults. We showed our concerns to the provider's specialist support practitioner who told us they were reviewing the plans and agreed with our findings.
- People's support plans did not promote independence. We saw people had plans in place to work towards certain goals and outcomes. For example, for one person this was to develop money handling skills and to clean their bedroom daily. There were sections for staff to fill in on how to take these steps and who will support them to achieve the goals. However, no information had been filled in to evidence how they were working to achieve their goals.

Ensuring people are well treated and supported; respecting equality and diversity

- We received mixed responses when we asked health professionals if they thought staff are caring. A health professional told us, "There are some staff who seem caring but also there is a high proportion of agency

staff, some of them are regular agency staff but at times, staff may not be always familiar with service users and their needs". Another health professional said, "There are a select few staff who genuinely care about the service users and their wellbeing". Another health professional told us, "I do believe that there are a few staff who genuinely care about the service users and their wellbeing. However, the lack of guidance and staff culture tends to shadow this".

● During our observations during our inspection we saw some positive interactions that demonstrated that staff knew how people liked to be supported. However, most of the interactions did not promote this and staff did not always seem confident in supporting people and knowing what they wanted. For example, when we visited people we were not introduced or explained who we were which made people anxious.

Failure to treat people with dignity and respect and support their privacy and independence. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● Staff we spoke with told us they gave people choices in how to live their daily lives and that they were able to make these choices. However, we could not see any people involvement in their care plans or reviews.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People did not always receive personalised care which met their needs. A health professional told us, "Little to no proactive person-centred support evidenced during my involvement, and I believe a lot of the behaviours of concerns I have noted can be influenced by addressing basic care provisions".
- Assessments were undertaken to identify people's individual support needs and their care plans were developed. However, these were not always sufficiently detailed, updated or supported by staff. For example, one person was at risk of malnutrition and needed continued encouragement to live a healthy lifestyle. We could not see where staff had supported with this and most of their activities involved watching a DVD and not supporting exercise. Their care plan also advised staff they were learning to develop their cooking skills and to encourage the person to choose and prepare a healthy meal every Monday. Records showed that most of their meals consisted of toast and burger and chips and did not promote the care plan.

- There was a lack of meaningful activities happening within the service. A health professional told us, "Generally service users don't seem to be engaged with in house activities. Offered to generate ideas for meaningful activities and plan these with team but this was not taken up". Another health professional said, "For some individual's activity levels are low within the service and also accessing the community".
- During our inspection activities displayed consisted of mainly going out to fast food outlets, for a walk or a drive. However, this was not always possible due to the lack of staff being able to drive the shared car. Records showed for one person their activities mainly showed watching a DVD. Other planned activities for people just had 'indoors' written in for the day, but no plan of what activities were planned for indoors.
- There was nobody receiving end of life care at Water Lane when we inspected. At our last inspection the provider told us they had started to engage with people's families about choices for end of life care. However, we could not see that this had been progressed. This meant is there was a sudden decline in someone's health, the service would not be aware of their preferences at end of life.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Most people living in the home at the time of our inspection did not express themselves verbally. We spoke to one staff member who told us for one person they are able to communicate well with them and they have

no negative behaviours. We were concerned if they were with agency staff they wouldn't always be able to communicate with them which can cause frustration and would react by showing behaviours that challenge.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to go out in the community. However, on two of the days of our inspection we noted one person was unable to go out due to the high use of agency staff who were not insured to drive the house car. This meant the person, who likes to go out for drives, had to stay at the service.

● Health professionals were concerned about the lack of community engagement with people following their interests. One health professional told us, "I feel that Water Lane can be overly risk averse. One gentleman has minimal input into the community, often only going for drives due to staff's anxiety around their behaviours. He also has limited access to his kitchen and availability to activities resulting in him spending his day watching TV." Another health professional said, "The staff do not seem to be engaging proactively with the service users, there seems little evidence of the service users being proactively supported with their communications, community access, activities at home. Data collated provided evidence of some of the service users having limited access to community, e.g. the provider reported that one of the service users was supported to go out for 'drives' but was not supported to leave the car for over a year."

●A relative told us, "We are worried that [persons name] is not going out. Another health professional told us, "Staff take service users on trips and their ability to fully engage is limited as not risk assessed e.g. they cannot get out of the vehicle, and instances of not taking items such as a drink with them/spare clothing. Previously I observed a member of staff on their phone when they were with service users."

People were not receiving personalised care and were at risk of social isolation due to the lack of activities and meaningful interactions available to them. This was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Improving care quality in response to complaints or concerns

● The service had a complaints procedure. However, records showed that there had been no complaints within the service. We checked this with one of the interim managers who informed us that they were not aware of any complaints received.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- At the time of inspection there was no registered manager in place and no one had been appointed to the post. The service was currently being managed by two interim mangers from different services within the company. However, one manager was only around for the first three days of the week and had only recently been involved and the other manager said they were available if needed. This caused inconsistency and confusion as when we raised an issue with one manager we were told that the other manager was dealing with it and to speak to them and vice versa. We were concerned there was ineffective management and no clear overall management oversight, and this was confirmed by relatives and health professionals
- A relative told us, "I would be happy if they had a permanent manager there all the time. Then I could speak to them and discuss [person's] care. I am their appointee and am really interested in their life and what they do but I just don't get the answers. I am happy for [person] to be there on the condition they have a manager there as [person] is really happy there". Another relative said, "Keep changing manager, we ask for schedules and they are not forthcoming. We are concerned".
- All the health professionals we spoke with felt the service was not managed well. One health professional told us, "The service seems to lack consistency in management, clear guidance, reflection on issues that may be going well or not working well. There seems to be lack of consistent governance in processes and ability to form improvement plan that could be easily implemented and sustained". Another health professional said, "The area manager appeared to be wanting to effectively engage and promote positive change but recently, there seems to be less progress made".
- There was a clear lack of management oversight at the service which had resulted in poor outcomes for people. The local authority had worked with the service and requested an action plan for the service on improvements needed to provide better outcomes for people. Person centred planning meetings started at the beginning of the year, however there were still actions to be completed. These were mainly due to staffing, poor record keeping and lack of management oversight.
- The governance arrangements needed to be strengthened and developed. There were no regular checks or audits completed by the manager of the service; however, the provider had completed an audit recently and had found that the service was not compliant with the regulations. For example, poor records keeping, lack of health and safety checks and the safety and suitability of the premises and the ongoing support for staff. This meant people were not safe and staff were not appropriately supported.
- The provider's quality assurance processes also confirmed our concerns. The provider had an internal

audit carried out in August 2019 and had achieved a score of 16 % compared to 80 % the previous year. This met the providers threshold as 'very poor'. Concerns raised included, poor support plans and records and lack of health and safety checks as there was no management presence.

● Incidents and accidents were recorded by staff. Whilst a log of these incidents was kept, there was no review of any patterns and trends completed for these and no learning outcomes identified from these. Incident and accident forms often lacked clear information on actions taken, learning outcomes and any further information used to inform plans of care for the person. This had not been identified by managers during their reviews of incidents and accidents.

● We were concerned that learning was not effective to help reduce the risks of repeat incidents and keep people safe. Following the incident where a person had access to items harmful to them, we spoke to the shift leader the next day about measures put in place to keep them safe. However, they had no knowledge of the incident and were in charge of leading the staff members supporting the person that day.

● Environmental and safety checks were not always taking place which put people at risk. For example, for one person when they are anxious they may drink excessive amounts of water and so has a fluid recording chart and a DOLs in place so that the kitchen can be locked during these times. As a result, containers that can be used to collect water from his bathroom flat should be removed. However, we saw an empty water bottle in their room in one of the drawers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Health professionals we spoke with did not feel this was a well led service. One health professional told us, "The lack of consistent management and governance of the service has made the work and any progress quite difficult, despite the staff involved trying to improve the situation at Water Lane". As well as, "The service has not had consistent management support since last year. The lack of consistent management and guidance seems to continue to have impact on the staff team and general culture, their morale and general ability to provide high quality of support." Another health professional said, "I do not consider Water Lane are providing high quality care. There is evidence of poor management of the wellbeing of the service users".

● There was a lack of positive leadership and guidance in the home which had led to a poor culture and care that was not person-centred, dignified or respectful. This had become an accepted part of staffs' day to day practice and had not been addressed by managers.

● Staff were not clear on the importance of their roles. There were numerous missing records in peoples notes as discussed throughout the report. A relative told us, "Paperwork isn't good. I always have to apply for [person's] blue badge. Basically, I have to go and do it as I get tired of waiting for them to do it for them".

● The recording of behaviours that may challenge did not always match in different sections of people's records. For example, the daily notes included an arousal level section which is a traffic light recording system, green, amber and red. These were not being consistently completed, even when the written notes detailed behaviours that had challenged the staff. We saw instances where the person had heightened behaviours and staff had recorded on the daily notes green and a good day. We also saw instances where behaviours had occurred, but no incidents had been recorded. A staff member told us, "The use of agency staff is different and would affect him. Used to have permanent staff who looked after [person's name] but since staff's hours been cut, a lot more agency staff in use which has resulted in more behaviours".

● We discussed the discrepancies with the recording forms and the recording systems ratings with one of the interim mangers, they told us, the issue had already been picked up as part of a specialist support team monitoring and that staff don't have a consistent approach or understanding of behaviours and what they mean.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were not supported to be involved in the running of the service. A relative told us, "There are no residents or relative's meetings that I have been told about". There were no meetings with people and records did not show any involvement with their care and support.

● Staff did not feel supported by management and as a result staff morale was low. One staff member told us, "I think there has been a lack of consistent management and as a result a lack of supervision and in turn has led to low morale really which I think you can pick up on". Another staff member said, "Everyone understands the problem trying to sort out, but bigger problem is why upper management don't have communication with anyone here, shouldn't be hard to order things. We need a proper management, not having that structure for all staff, so team managers and residents get affected. Request things but don't feel listened to or supported".

● As a result of not having a registered manager staff meeting had not taken place regularly. The interim manager told us, "Staff morale not at its best I would say, so had a team meeting before I went on leave and another one booked in to try and boost staff morale". Staff meetings are an open forum amongst staff and are usually held to discuss concerns about people who used the service and to share best practice. Meetings can also be used to reinforce the values, vision and purpose of the service.

The lack of consistent and effective leadership, poor record keeping and poor governance in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

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 failed to ensure people were treated with dignity and respect. 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure there was a variety of nutritious food was not available to meet peoples. Regulation 14 (1)

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person centred care, support and care planning. People were not receiving personalised care and were at risk of social isolation due to the lack of activities and meaningful interactions available to them.

The enforcement action we took:

We will issue a notice of proposal to cancel registration for failing to comply with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The Provider had failed to ensure people were kept safe from harm. Systems to identify, assess and mitigate risks were ineffective. Regulation 12 (2) (a) (b) The provider had failed to ensure the safe and proper management of medicines. Regulation 12 (2) (g) The provider had failed to ensure the environment was safe and that the risk to people was minimised in the event of an emergency or evacuation.

The enforcement action we took:

We will issue a notice of proposal to cancel registration for failing to comply with the regulations.

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 failed to ensure people were

	protected from abuse and improper treatment. regulation 13 (1) (2) (3)

The enforcement action we took:

We will issue a notice of proposal to cancel registration for failing to comply with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were kept clean and well maintained. Regulation 15 (1) (a)

The enforcement action we took:

We will issue a notice of proposal to cancel registration for failing to comply with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems and processes to assess and monitor the quality of the service and to identify and mitigate risks. Records were not always accurate and completed. Regulation 17 (1) (2)

The enforcement action we took:

We will issue a notice of proposal to cancel registration for failing to comply with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to make sure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to support people. Regulation 18 (1) Staff were not supported with training and supervisions and ongoing support. Regulation 18 (2) (a)

The enforcement action we took:

We will issue a notice of proposal to cancel registration for failing to comply with the regulations.