Cornwall Council

Lowena

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit took place on 9 January 2019 and was announced. Lowena is a short break service run by Cornwall Council for adults with learning disabilities. Lowena is situated close to the centre of the city of Truro with all amenities being a walk or short drive away. The service provides single room accommodation for up to 25 adults with a learning disability, physical disability and people living on the autistic spectrum, who need assistance with personal care. Occupancy levels vary each week due to the nature of the service. The service is purpose-built on one site.

Lowena is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The registered manager had recently left their post and de registered with the CQC. There was an interim manager in post. The manager and two team leaders were responsible for the day-to-day running of the service. A registered manager is a person who has registered with the CQC 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.

As part of this comprehensive inspection we checked to see if the provider had made the required improvements identified at the inspection of 4 December 2017. At that inspection we found the service environment was not being maintained to a satisfactory level which had the potential to have a negative impact on people using Lowena. The heating system was not providing consistent heat throughout the service. There were six rooms which were not occupied at the time of inspection where radiators were not working. Some parts of the large lounges were cool to sit in. One room had a carpet which had a malodorous odour. Two specialist baths were not working, one had been de commissioned and required replacement, another was waiting for parts. There were two adapted showers which were being used by people until the baths were replaced and repaired. The general decoration of the service was not satisfactory. Walls were damaged and marked as was some woodwork surrounding peoples sinks in some rooms.

In addition, at the previous inspection in December 2017 survey feedback had highlighted some mattresses were hard and needed replacing. This was also highlighted by staff during the inspection. No action had been taken to address this. The quality of towels being used was poor. White towels were grey and coarse, two were frayed and not fit for purpose.

External areas of the service were not being maintained. A rear garden area could not be used due to the grass not being cut and therefore was too long to play ball games, which people had always enjoyed in good weather.

Governance systems were not effective. Oversight of the services environment had not identified and acted upon defects in a timely way. The decoration and overall general maintenance of the service was not being managed or reviewed effectively.

The views of people were not regularly formally sought and acted upon. A recent negative comment about mattresses had not been investigated and acted upon.

At this inspection we found governance systems were inadequate. There was an organisational lack of leadership and oversight to improve the services environment. The organisation had not acted upon defects in a timely way. The decoration and overall general maintenance of the service was not being managed or reviewed effectively.

From our findings during this inspection we noted quality audits had not identified the impact on people in respect of the temperature in the building. People using the service had complex needs. Many people were not mobile and most were unable to verbally communicate. This meant they were vulnerable and this had not been acknowledged or respected in any of the audits that had taken place.

Health and safety auditing had not identified the benefits of an alarm system for service users or staff. During this inspection we identified two rooms where overhead lighting above the sink was not operating effectively. These issues had been reported however the organisation had not responded. This demonstrated the providers response was ineffective. We have made a recommendation about this.

Senior manager checks to make sure mattresses had been replaced as reported on would have shown that what was in the records had not been carried out. This meant the oversight systems were ineffective and what had been reported on were not accurate or true records.

Environmental issues had not been actioned in respect of the maintenance of temperature, decoration and external maintenance. During this inspection we found the provider had not acted to improve the way the service was heated and to ensure all areas of the service was consistently warm enough for people to be comfortable in.

Limited decoration had taken place since the previous inspection. However, all rooms remained sparse. There were no pictures, lamps or items which would make rooms homely and inviting. Paintwork remained generally poor and scratched. Two rooms, including a bathroom, had not been decorated following repairs to the walls and looked unsightly.

The care service was established before the development of the CQC policy, 'Registering the Right Support' and other current best practice guidance. This guidance includes the promotion of values including choice, independence and inclusion. Action had not been taken to ensure the provider was working within the guidelines.

Medicine administration systems had been reviewed and were being monitored by managers. Auditing processes meant any omissions and stock control issues were being identified and managed more effectively.

The service had systems in place to record safeguarding concerns, accidents and incidents and take necessary action as required. Staff had received safeguarding training and understood their responsibilities to report unsafe care or abusive practices.

Risk assessments had been developed to minimise the potential risk of harm to people during their daily routines and delivery of their care. These had been kept under review and were relevant to the care provided.

The service worked with other health professionals and supported people to access healthcare professionals if required.

We found continuing breaches of the Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 17 of the Health and Social Care Act 2008.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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Requires Improvement

The service was not effective. Action to maintain the standards of the environment had not been addressed since the previous inspection.

New employees completed an induction which covered training and shadowing more experienced staff.

The service acted in accordance with the legal requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

People had access to other healthcare professionals as necessary.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Inadequate

The service was not well led. The provider had not ensured safe and appropriate maintenance checks had been made and acted upon regarding the electrical system and the services heating system.

There were inadequate governance arrangements in place to monitor and assure the quality of the service.

Lowena

Detailed findings

Background to this inspection

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

This inspection visit took place on 9 January 2019 and was announced. We gave the service 24 hours' notice of the inspection visit because the service was a respite service and people were not generally there during the day. We needed to be sure someone would be available.

The inspection team consisted of an adult social care inspector.

Before the inspection we reviewed the information, we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who use the service and previous inspection reports. We also checked to see if any information concerning the care and welfare of people who use the service had been received.

As part of the inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

People using the service had limited ability to communicate verbally. We spoke with two people with the support of staff. We made general observations. Following the inspection, we spoke with two family members. This helped us understand the experience of people who could not talk with us.

We looked at care records of two people, staff training records, supervision records of three staff members and arrangements for meal provision. We also looked at records relating to the management and governance of the service. We reviewed the services recruitment procedures and checked staffing levels. We also checked the building to ensure it was clean, hygienic and a safe place for people to live.

We spoke with a manager, two team leaders and four support staff. Following the inspection, we spoke with

an area manager for the service. Prior to the inspection we received feedback from three professionals who engaged with the service.

Good

Is the service safe?

Our findings

People we spoke with told us they felt their relatives were safe using the respite services at Lowena. Their comments included, "Feels safe with [family member] using the service" and "I know [family member] is safe there would never doubt it."

Staffing levels had been reviewed and changes to shift patterns meant there was more flexibility in how the service was staffed. The rotas showed there were sufficient numbers of staff deployed to meet people's needs. However, as reported in a staff meeting in September 2018 there had been 37 cancellations of respite places since July 2018 due to staff shortages. The interim manager told us the revised rota appeared to be working as there was now more flexibility to ensure there was enough staff to support people and therefore less chance of cancellation. This is a service which is relied heavily on by families and cancellation of respite time would have a negative impact on people and their relatives. A staff member said, "There have been a lot of talks and meetings about our rotas. We [staff] proposed a new rota and it seems to be working well."

Lowena provides respite care for people with disabilities. People brought their medicines with them when staying at the service. There were suitable systems to check this medicine in and out of the service and administer it as prescribed or directed.

Medicine audits had increased since it was identified that some medicines being dispensed as PRN (medicines given as needed) were not always being recorded. This meant there was a potential risk to people because there was no record of how much medicine had been administered and when. As a result of the audits staff had received additional training and support. The improved system protected people by recording when the medicine had been administered, why and what time.

Each person had information held at the service which identified the action to be taken in the event of an emergency evacuation of the premises. The services fire systems were being regularly checked to confirm they were working effectively. However, a recent test resulted in the system failing. Immediate action was taken to rectify this to ensure the system was fully operational.

Records were available confirming equipment was being serviced regularly. However, a recent electrical service had recorded the system as 'unsatisfactory' with recommendations in place. There was no evidence to show what action had been taken and the timeframe in which the recommendations would be addressed. This is reported on in more detail in the well led domain of this report.

Incidents and accidents were recorded in the service. There were no identified patterns or evidence of a high reporting of accidents or incidents. However, where they occurred any accident or 'near miss was reviewed to see if lessons could be learnt and to reduce the risk of similar incidents.

A safeguarding policy and information on how to report any concerns, was available to staff. Safeguarding training was included in the induction process for new staff, and was refreshed regularly. Safeguarding issues were also discussed in supervisions and staff meetings. Staff were knowledgeable and able to

describe to us what they would do if they suspected any harm.

Care plans had risk assessments in place to identify potential risk of accidents and harm to people. Risk assessments provided instructions for staff members when they delivered their support. These included nutrition support, medical conditions and mobility. The assessments had been kept under review to ensure support provided was appropriate to keep the person safe.

The provider's recruitment procedures included all the required pre-employment checks. These included identity checks, two references and Disclosure Barring Scheme (DBS) checks. DBS checks help to keep those people who are known to pose a risk to vulnerable people out of the workforce.

All staff had received infection control training and understood their responsibilities in relation to infection control and hygiene. Hand washing facilities were available around the building. These were observed being used by the staff member whilst undertaking their duties. This meant staff were protecting people who used the service and themselves from potential infection when delivering personal care and undertaking cleaning duties.

Requires Improvement

Is the service effective?

Our findings

We checked to see if the provider had made the required improvements identified at the inspection of 4 December 2017. At that inspection we found the service environment was not being maintained to a satisfactory level. The heating system was not providing consistent heat throughout the service. There were six rooms which were not occupied at the time of inspection where radiators were not working. We found the lounges were cool to sit in and not consistently heated.

During this inspection we found the provider had not acted to improve the way the service was heated and to ensure all areas of the service was warm enough for people to be comfortable in. We found the service to be cool throughout on arrival at 1pm. It did not get any warmer in any area of the service prior to more checks being made on the arrival of people at 4pm. Comments from staff included, "There are still things not right [heating]" and "We've been told that the new heating will not cope with the old radiators" and "They are old radiators. The heating is all over the place it can be warm in some parts and cold in others. Tends to be the further you move away for the boilers the colder its gets."

Two specific areas of the premises were being regularly used. The internal flat had recently been decommissioned. However, only one area was being used on the day of the inspection. We checked the lounge, dining area, bathrooms and bedrooms to see if the temperature was comfortable in these areas. We found the lounge and dining area was cool. There was one heating source in this area. This was a radiator which gave off very little heat. A staff member told us there was a portable radiator and this could be used if necessary. However, due to the size of the room this would have had little effect. We checked nine rooms, eight of which were being occupied that night. Radiators were either delivering no heat or very little heat. People received personal care in their bedrooms and the temperature would not have ensured they were comfortable when this care was being delivered. In addition, two of these rooms had overhead lighting above the sink which was not operating effectively and was flashing on and off. This had the potential to have a significant impact on people because those using the service had complex needs. Some people were not mobile and most were unable to verbally communicate to staff if they were cold or in discomfort.

The services environment monitoring records from the 3rd to 21st December 2018 reported the temperature of all rooms and lounge areas was recorded as between 20-21 degrees centigrade. However, during this inspection and the previous inspection we found radiators were not effective in delivering a heat source which would ensure comfort for those using the service. This demonstrated there were inconsistencies in temperatures.

At the previous inspection we found two specialist baths were not operational and therefore adapted showers were being used. At this inspection we found one of the two baths had been repaired with the other one decommissioned. An additional shower facility had been put in place to address this.

At the previous inspection we found the general decoration of the service was not satisfactory. This was because there was a lack of decoration, walls were marked due to damage by equipment being used. Where damaged walls had been repaired they had not been decorated. Woodwork was chipped and paintwork

damaged. At this inspection we found there had been some decoration in individual rooms. However, all rooms remained sparse. There were no pictures, lamps or items which would make the room homely and inviting. Paintwork remained generally poor and scratched. Two rooms including a bathroom had not been decorated following repairs to the walls and looked unsightly. The lack of decoration and personalisation of private rooms did not support people's emotional well-being.

The previous inspection noted survey feedback had highlighted some mattresses were hard and needed replacing. This was also highlighted by staff during the inspection. At this inspection we found four mattresses were hard and when sat on the spring interior could be felt and was uncomfortable. Three specialist mattresses were covered with a thin sheet and required a mattress topper to ensure comfort.

In December 2017, we found external areas of the service were not being maintained. A rear garden area could not be used as the grass had not been cut and was too long to play ball games, which people had previously enjoyed in good weather. At this inspection we were told the service relied on volunteers to maintain the garden areas. This included courtyards and the main garden area from March to October. This meant the provider was not taking responsibility to maintain its external areas.

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

The monthly health and safety record for November 2018 reported on the need for intumescent strips (a piece of material fitted around a doorway that, when exposed to heat expands closing any gaps] to be installed on the independent internal flat bedroom doors following the fire service inspection. At the time of the inspection the internal flat was not being used. One person using the service benefitted from using this flat but was unable to use the it until the work had been completed. The area manager told us once the work had been completed people may use the communal area of the flat if required but that it was not intended to be occupied at night.

Staff told us they felt supported by managers and they had access and support when they needed it. Some staff told us formal supervision had improved and there were less gaps in records than there had been. Records showed staff had been receiving regular supervision during the past twelve months. Senior staff supervised support workers and this was shared by the management team. One record reported on three consecutive months that the support worker was anxious working alone at night. This was due to concerns that they may not be able to summon the sleep-in duty member if they needed urgent support. This had been discussed and documented there was evidence to show how it was being actioned and what steps had been taken to support the member of staff. The rotas we viewed showed there were two staff on duty at night.

We noted there was no emergency call system other than in the toilets and bathrooms. It was clear there had never been an emergency call system installed in people's rooms. Most people using the service had complex physical and learning difficulty needs. However, as reported in the effective domain of this report some staff were concerned that they had no way of alerting other staff for support in the event of an emergency in a person's room.

It is recommended the service reviews systems available to support people and staff to ensure health and safety procedures are robust. It is recommended the service follows good practice guidelines to ensure staff are supported in their working environment.

In December 2017 we found one room had a carpet which had a malodorous odour. At this inspection we

found flooring in most rooms had been replaced by a more suitable material. There were no malodorous odours.

At the previous inspection we found the quality of towels being used was poor. White towels were grey and coarse. Two were frayed and not fit for purpose. At this inspection we found towels had been replaced to ensure the comfort of people when receiving personal care.

The manager and team leaders told us training had improved. One person said, "We did slip behind when the council withdrew its training department but we care back up and running now with good face to face training and e-learning." All levels of staff had access to training which reflected the needs and levels of their individual roles. This included safeguarding, fire safety, health and safety, infection control, equality and diversity and nutrition. Staff had received training to support people with learning difficulties, autism and epilepsy. Some staff had achieved national care qualifications. This ensured people were supported by staff who had the right competencies, knowledge, qualifications and skills. A health professional told us the service was very responsive and made sure staff had the knowledge and skills to carry out their roles."

Staff had an induction when they started employment with the organisation which involved them completing the Care Certificate if they had not worked in a care setting before. The Care Certificate is a national qualification designed to give those working in the care sector a broad knowledge of good working practices. There was also a period of shadowing more experienced staff.

People's needs were assessed to help ensure their physical, mental health and social needs were known and recorded in a range of care plans. For example, where a person was very quiet and had times when they liked to be on their own. There was guidance for staff on how to support the person during these times.

Care records showed people continued to have support from a range of health and social care services to monitor and maintain their health and well-being. Information about external professional reviews and appointments was clearly recorded in care records to ensure staff were aware of any changes in needs.

People received meals which were wholesome and freshly prepared. Staff told us the service now ordered and managed their weekly food order. This had meant more flexibility in the range and choice of meals. People using the service were encouraged to give their views. Staff told us there was much more choice for things they knew people liked. On the evening of the inspection staff had prepared a curry. People were seen to be enjoying the meal. Some people also helped in the kitchen to prepare meals. One staff member told us, "At weekends it can get really busy in here but it's a good atmosphere." There was fresh fruit available in the kitchen for people to choose from.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 staff working in this service made sure that people had choice and control of their lives and supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

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).

Care plans recorded consent on care planning records. However, this was printed and in most instances people lacked capacity to make decisions about consent. The service also had a social media account which was a closed group, therefore only people invited could access this group. Staff told us if people did not have capacity to consent then their next of kin would be asked. However, there were no records to evidence relatives had the legal authority to make decisions on people's behalf or that decisions had been made in line with the 'best interest' process as defined in legislation.'

It is recommended that for good practice the service ensure decisions taken on behalf of people who lack capacity are carried out in line with legislation laid out in the MCA (2005The service was designed to ensure equipment required for some people could be adequately accommodated and used safely.

Good

Is the service caring?

Our findings

Throughout the inspection we observed care practices and how staff interacted with people they supported. All staff were observed to be kind, caring and patient with the people they supported. They were polite and attentive and quick to respond to people who required their assistance. Staff knew and understood people's history, likes, dislikes, needs and wishes. They knew and responded to each person's diverse needs and treated people with respect and patience.

We observed several instances of caring interactions between staff and people who used the service. We heard staff and people laughing together. Where people wanted to be quiet a staff member supported them away from the area where most people had settled. This had a positive response and it was clear the staff member knew the person's needs and how to respond to them in a caring and respectful way. Another person was being comforted by a staff member. The person responded with gestures that indicated they appreciated the support they were receiving.

People using the service had limited capacity to verbally communicate, however they were supported by staff to engage with us. A staff member supported a person using sign language and this helped with a positive engagement and information sharing. Some staff had received training in sign language and Makaton (a sign and symbol language to support communication).

People's privacy was respected. People were supported to the privacy of their bedrooms if they wanted to go to their rooms. One person preferred their own company and staff supported them to use an area of the service which was private to them. Some people liked to sit on their own or move around independently. Staff were observed overseeing their wellbeing while giving the person their own personal space.

Discussion with the staff revealed that people who used the service had a range of diverse needs in respect of some of the seven protected characteristics of the Equality Act 2010. This included, age, disability, gender, cultural background and sexual orientation. The service was accommodating of people's needs and staff responded well to the diversity within the home and understood the importance of treating people individually and upholding people's rights.

Care files and information related to people who used the service. There was a locked store facility which was accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines. However, individual files were kept in a lounge area where there was a staffing station when people arrived for a short stay.

We recommend the service ensures peoples information is always kept securely to ensure the service is meeting the requirements of the data protection principles under General Data Protection Regulations [GDPR].

No-one using the service required an advocate. Managers and staff understood the importance of advocacy for independent support and had contact details if required. This helped ensure people's interests would be

represented and they could access appropriate services outside of the service to act on their behalf if needed.

All the staff we spoke with were knowledgeable about people's needs and could describe these to us. Staff could explain their roles and responsibilities especially relating to how they cared for people. They told us, "Just focusing on the guests needs is the most important thing" and "We have been supporting some of the guests for a long time and so we [staff] know their needs very well."

Good

Is the service responsive?

Our findings

We found the service provided care and support that was focused on individual needs, preferences and routines of people they supported. Staff supported people and encouraged them to enjoy the respite visits to Lowena. Families told us, "We get phone call from the key worker and are involved in reviews" and "Always get to know what's happening or changing. The staff are very good at keeping me up to date."

People had 'hospital passports' these included information about the person in an easy read format to use if they needed health appointments or hospital admissions. This ensured personal information about people, including needs, wishes and preferences was available in urgent situations or when they were unable to make their views known. These could then be considered by staff and other external professionals such as paramedics and doctors, who are required to provide additional care and treatment. 'Hospital passports' are used when people move between the service and a hospital to help ensure effective communication.

People had the opportunity to access the local community. Some people attended local day centres within the area. Staff also supported people to access local events. For example, recent Christmas events in the local area. One person told us they enjoyed going shopping with a support worker. They told us what they liked to do and showed us the clothes they liked to buy when on shopping trips. It was clear this had been a positive experience for the person. Staff said, while there was transport it was limited and sometimes it was only possible for people to go out as a group. This meant external activities were not always organised to meet individual needs, preferences and interests. There were regular activities in the service, with music and films being provided. A pool table was available for people to use. Staff told us about the regular parties and cooking sessions. Photos of events displayed in the service were dated. For example, one was six years old and was of people who were no longer using the service. Staff agreed they should be replaced and updated.

Care plans contained information on how people communicated and how they could be supported to understand any information provided. This meant the service was identifying and recording people's needs when accessing information in line with the Accessible Information Standard (AIS). The AIS is a framework making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had picture boards to help communication. For example, pictorial menu boards. There was a large wall board intended on supporting people to understand what was happening in the service. This was not being used as effectively as it could be because some areas were blank. There were photographs of staff who could specifically help people with communication as they had the knowledge and skills to do this.

Care plans were generally person-centred and detailed people's individual needs and preferences. Each person had a care plan for most aspects of their daily lives in which they needed support, such as personal care, mobility, social needs and nutrition. The service ensured all needs [not just physical needs] were met, such as social, emotional and religious. This meant information was available to staff to ensure they provided care and support in the way a person preferred. Initial and on-going reviews were carried out to ensure the service continued to meet people's needs appropriately.

The service had a complaints procedure which was available to people. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

Inadequate

Is the service well-led?

Our findings

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service did not have a registered manager in post. The registered manager had left their post and voluntarily de registered with the commission shortly before the inspection took place. The provider had made an interim provision for an acting manager to oversee the service while managing another service. They were being supported by two team leaders. The organisation was actively seeking to recruit another manager.

During the inspection in December 2017 we found governance systems were not effective. Oversight of the services environment had not identified and acted upon malfunctions in a timely way. The decoration and overall general maintenance of the service was not being managed or reviewed effectively. The views of people were not regularly formally sought and acted upon. A recent negative comment about mattresses had not been investigated and acted upon.

We looked at what action had been taken to improve governance systems. We found the environmental issues had not been addressed. This is reported on in the effective domain of this report. There were monitoring systems in place but they had not been effective in addressing the issues found during the last inspection.

There were inadequate governance arrangements in place to monitor and assure the quality of the service. Quality audits had not identified the impact on people in respect of the temperature of the service. People using the service had complex needs. Many people were not mobile and most were unable to verbally communicate. This meant they were vulnerable and this had not been acknowledged or respected in any of the audits that had taken place. The failure of the provider to act to meet the environmental and governance issues at Lowena meant there was a risk of people not receiving the standard of care and support they required.

Audits were not effective. For example, a daily environment audit reported on room temperatures. The audit did not report on the time of day the temperature was taken or how it was measured. There was no heat monitoring equipment in people's rooms and so it was unclear how temperatures had been evidenced. Staff we spoke with during the inspection were not aware of the equipment used to report on individual room temperatures.

Records indicated mattress audits were taking place, however during this inspection we found four mattresses were unsuitable and required replacing. Staff we spoke with also told us they felt the mattresses were no longer fit for purpose and needed replacing. Others required additional bedding to ensure they were comfortable. Health and safety auditing had not identified the benefits of installing a system to alert staff to emergencies. During this inspection we identified two rooms where overhead lighting above the sink was not operating effectively. This was clearly identifiable as the lighting was flashing intermittently when

we looked at it during the inspection. These issues had been reported by the service but the provider had not yet acted on it. This demonstrated the services approach to auditing were ineffective.

A fire service visit in July 2018.had recommended intumescent strips were put in place on the internal flat bedroom doors. People could not sleep in the flat until this was addressed. This had a negative impact on a person using the service who used the flat as an area they felt most comfortable. No action had been taken by the provider to address this. Following the inspection, the area manager informed us that the provider had taken the decision to decommission this part of the service. This meant that people who would benefit from this sort of independence were going to be disadvantaged due to a governance decision.

The care service was established before the development of the CQC policy, 'Registering the Right Support' and other current best practice guidance. This guidance includes the promotion of values including choice, independence and inclusion. Action had not been taken to ensure the provider was working within or towards the guidelines. This meant people living at the service may not have their independence or inclusion maximised in their best interests.

There was no evidence the provider was committed to driving improvement within the service. When shortcomings had been identified, such as the need to improve fire safety in the self-contained flat, rather than make the required improvements the provider chose to withdraw this aspect of the service at the detriment of people. The provider had failed to recognise the importance of the environment and the potential impact on people's emotional well-being. No attempt had been made to create a pleasant and homely atmosphere in people's bedrooms which would support people in the transition between home and the service.

Despite being assured by the registered manager that action had been taken to meet breaches of the regulations identified at our previous inspection, we found this was not the case. It demonstrated management systems and overview of the service were ineffective. This did not evidence the provider had effective oversight of the service, or had robust systems in place to monitor the service and ensure the actions from the previous inspection had been taken. The absence of this provider oversight had resulted in the reduction in quality of life for people who were living in a poorly heated and decorated service. Most people using this service were unable to communicate any concerns verbally or express they were cold or in discomfort. No systems had been implemented by the provider to support.

Senior management visits to discuss operational issues and check management records had taken place. However, these were not effective and had failed to identify shortcomings in the service. Checks to make sure mattresses had been replaced would have shown that, what was recorded in the records we reviewed had not been carried out. Daily temperatures could not be relied upon as we found that on two inspection visits, we have found inconsistencies in the level of heating in the building. This meant the oversight systems were ineffective.

There were systems in place to gather staff views such as staff meetings and supervisions. However, while the service had recognised some staff were concerned that there no system in place to call for additional support in an emergency as there was no emergency call system in place or any other way to communicate with each other throughout the service. There was no evidence the provider had acted to address this identified risk and to ensure alerts could be made in the event of an emergency.

We shared our initial concerns with the Nominated Individual following the first day of the inspection. Due to the impact of the ineffective heating system and the potential for this to greatly impact on people who were vulnerable and could not easily raise concerns we have referred this issue to the local authority safeguarding

team for investigation to protect people.

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

Since the previous inspection we found there were now improved systems for gathering the views of stakeholders, including family and advocates. There had been a guest survey which was positive about the support people experienced. Relatives told us they were asked for their views during reviews, or when picking their relative up following a respite visit. Another person told us they got to know about their relative's activities by looking at the 'chat' book. They said it showed they were very busy and active. People told us they received a survey from time to time and another person told us they had been to a coffee morning. The service had a 'Friends of Lowena group', which raised funds and gave people time to share information.

Despite the above concerns, families told us the service was very valuable to them and they felt their relative was supported by caring staff which was important to them. They told us, Without Lowena I wouldn't have any respite. Staff are always so nice and polite," "A wonderful service. So grateful" and "Staff are there for love. Been there a long time. Always the same staff. "Staff members were positive about the way they worked together. A health professional commented that the registered manager was responsive to advice to improve the service. They said, "I am very pleased with quality of service provided by Lowena. I have always been impressed by their willingness to go over and above and assist in an emergency. Service users enjoy their time there and remain keen to attend."

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 registered provider was not ensuring the premises were being suitably maintained so that service users and others were protected against the risks associated with an unsuitable environment.

The enforcement action we took:

We imposed a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have effective systems in place to regularly assess and monitor the quality of the service provided and identify, assess and manage risk relating to the health, welfare and safety of the people who use the service.

The enforcement action we took:

We imposed a condition.