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Grove Villa Care

Inspection report

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Tel: 01304364454

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 January 2018 and was unannounced.

Grove Villa Care is a care home registered to provide accommodation and personal care for up to 16 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People using the service had a range of physical and learning disabilities. Some people were living with autism and some required support with behaviours that challenged.

The service had a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission (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.

We last inspected Grove Villa Care on 20 April 2017, we found significant shortfalls and the service was rated inadequate and placed into special measures. The provider and registered manager had failed to notify CQC of notifiable events in a timely manner. Risks relating to people's care and support were not always adequately assessed or mitigated. Medicines were not managed safely. The provider had not ensured that staff had all the training they required to meet people's needs, support them consistently and keep them safe. The provider and registered manager had failed to enable and support people to communicate their preferences. People did not always receive care and support in the way they preferred and were not enabled to understand their care and support options. People did not always receive person-centred care. Staff and the registered manager were not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. People were not fully protected from abuse and the registered manager had not followed the correct procedures to make sure people were as safe as possible. The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to respect and involve service users and had failed to maintain accurate and complete records.

We took enforcement action and issued a warning notice relating to 'Safe Care and Treatment.' We placed a positive condition on the provider's registration, asking them to send us monthly updates regarding the service. We required the provider to make improvements and the service was placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. At this inspection we found that improvements had been made in some areas, however there were still serious concerns regarding the provider's oversight and overall management of the service and some continued breaches of the regulations.

The service was not fully working towards Registering the Right Support and other best practice guidance.

These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. Some people were not allowed to access their kitchen, even though they wanted to, as staff described it as 'unsafe.' No risk assessment had been completed regarding the risk of people using the kitchen and no plans were in place to increase people's independence and skills.

At our last inspection, risks relating to people's care and support had not always been assessed and mitigated. At this inspection the registered manager and deputy manager had begun to re-write people's care plans. Nine of 16 had been completed. The new care plans contained more detail regarding how to give people appropriate support, such as how to recognise and respond if they experienced a seizure or displayed behaviour that challenged. However, there was still a lack of essential guidance for staff if people choked. The care plans that had not been updated still did not contain information regarding people's seizures and when staff should seek medical assistance. When incidents occurred the deputy manager now completed an overview of incidents to look for patterns and trends and ways of reducing the chance of them happening again.

Staff did not always treat people in a respectful manner. They had written that people were 'hoarders' and 'messy eaters' and had given no consideration to how people may have felt to be described as such. A staff member had headphones in throughout the inspection and ignored people when they spoke to them.

A communication board had been introduced which enabled people to make choices between different things such as different foods and activities by using pictures. The registered manager and deputy manager had chosen not to implement a recommendation from a speech and language therapist regarding a visual timetable for a person and told us they were using the communication board instead. The communication board did not provide the same support as a visual timetable.

Staff had not received training in best practice for supporting people with learning disabilities. The registered manager lacked the knowledge and understanding regarding supporting people with learning disabilities. Although some care plans had been re-written since our last inspection, people's needs had not been assessed in line with best practice as a result.

People were going out more regularly since our last inspection and the deputy manager regularly monitored when people were going out and how often. The registered manager completed checks on the service, but had not identified the issues we highlighted at this inspection. The provider lacked oversight of the service. They did not complete any formal checks and the registered manager had not received regular supervision. We requested information to be sent after the inspection, and this was not received in a timely manner. Although some action had been taken since our last inspection both the provider and registered manager had failed to acknowledge the severity of the issues identified and the breaches had not been met fully. We had not been notified of safeguarding incidents that occurred within the service, as required by law and staff had not been recruited safely.

People and their relatives were asked their views on the service annually, but had not been asked formally, since our last inspection. The service had received some support from the local authority safeguarding and commissioning teams since our last inspection. They were working with the registered manager and staff to encourage improvements. There were enough staff to keep people safe. Medicines were now managed safely and people received them as and when required. People received support to manage their health care needs, and saw a doctor when they became unwell. People were supported to eat and drink safely. The

service was not currently supporting anyone at the end of their life

Some areas of the service had been re-decorated since our last inspection and people had been involved in choosing the colours of the walls. The service was clean and people were protected from the spread of infection.

The registered manager told us there had been no complaints since our last inspection. The registered manager had applied for Deprivation of Liberty Safeguards when people's liberty was restricted.

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?

Inadequate

The service was not safe.

Staff did not always have the necessary guidance to keep people safe. Some analysis was now completed when incidents occurred.

Staff were not always recruited safely.

There were enough staff to meet people's needs.

Medicines were managed safely.

The service was clean and people were prevented from the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received the necessary training to provide effective care. The registered manager and staff lacked knowledge regarding best practice when working with people with learning disabilities.

The registered manager had applied for Deprivation of Liberty Safeguards (DoLS) when people's liberty was restricted.

Some areas of the service had been re-decorated since our last inspection and people had helped choose the colours of the paint.

People received the support they needed to manage their healthcare needs. Staff had made referrals to healthcare professionals when people's needs had changed.

People were supported to eat and drink safely.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always refer to people in a respectful manner.

People were not supported to be as independent as possible and some people were unable to access their kitchen.

Staff had introduced some additional ways to support people with their communication.

We observed some kind and caring interactions throughout the inspection.

Is the service responsive?

Inadequate

The service not consistently responsive.

There were no plans in place to develop people's independence or encourage them to learn new skills.

People were going out more regularly since our last inspection.

There had been no complaints since our last inspection.

The service was not currently supporting anyone at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

The providers of the service lacked oversight and failed to ensure the registered manager had the necessary skills and knowledge to carry out their role.

The provider and registered manager had failed to notify us of important events that happened within the service.

Checks and audits had failed to identify the issues we highlighted at this inspection.

The local safeguarding and commissioning teams were working with the service to try to encourage improvements.

People and their relatives were asked their views on the service annually, but had not been asked formally, since our last inspection.

Grove Villa Care

Detailed findings

Background to this inspection

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

This inspection site visit took place on 16 January 2018 and was unannounced. The inspection was carried out by two inspectors.

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. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager, the deputy manager, a senior and two members of care staff. We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

During the inspection we spent time with and spoke with the people living at the service. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we spoke with the local authority commissioning team about our concerns.

Inadequate

Is the service safe?

Our findings

At our previous inspection, risks relating to people's care and support had not been adequately assessed and guidance for staff did not contain the level of detail necessary to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the registered manager and deputy manager had begun to re-write people's care plans. One of the re-written care plans now contained guidance for staff regarding how to recognise when a person experienced a seizure and what action staff should take to keep them safe. The deputy manager had created a simplified flow chart for staff to look at quickly in an emergency and this was accurate and detailed. Staff told us they know to respond if people had a seizure and had responded in a timely manner to administer people's emergency medicines..

Although work had begun to re-write people's care plans, only nine of the 16 care plans belonging to people who lived at the service had been completed. One person was living with epilepsy and there was no guidance for staff regarding when they should seek assistance from a medical professional if the person had a seizure.

One person was assessed as being at high risk of choking, as they chose not follow speech and language therapy guidance. Their care plan stated staff should have up to date, 'basic life support training, which includes how to deal with choking incidents.' However, it did not detail the action staff should take if the person choked. We spoke with staff regarding what they would do if the person choked. Staff were unable to consistently tell us the action they should take or when they call for medical assistance. One staff member said, "I would try and get them not to choke. I'd tap them on the back and lean them forward." Another staff member was unable to tell us the number of back slaps they would try, before attempting an abdominal thrust. They told us they knew it, but their mind, 'had gone blank.' Without guidance, there was a risk the person would not receive the essential support they required if they choked.

At our previous inspection, incidents of behaviour that challenged were not analysed to look for trends and patterns. This meant ways of reducing the risk of incidents happening again were not always identified. Incidents were now collated and the deputy manager showed us the monthly analysis they had completed. Although incidents had been collated, staff had failed to identify some consistent triggers, such as people wanting to access the kitchen. There had been multiple instances where a person had been told to leave the kitchen or was denied access because staff thought it was 'unsafe' or a 'health and safety risk.' When this occurred the person became distressed and displayed behaviour that staff found challenging. No consideration had been given to supporting the person to access the kitchen in a safe way.

The provider and registered manager had failed to ensure that staff had the necessary guidance in place to keep people safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection staff had received training in 'managing challenging behaviour.' Some people's care plans had been re-written and there was guidance for staff regarding potential triggers for people's

behaviours and how to respond. During the inspection some people became distressed and staff followed the guidelines in place. They supported people to remain calm, and determine what they wanted.

There was now clear guidance in place to tell staff how to support people to leave the service safely in an emergency. Each person now had a personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency

People were not supported by staff who had been safely recruited. Prospective staff completed an application form and attended an interview prior to beginning to work at the service. The provider requested that any gaps in employment be explained. These were not consistently checked. For example, one person had two separate gaps in their employment and only one had been explained on the application form. This had not been identified and discussed during the interview.

The provider requested that two references were obtained and that 'Family is not acceptable for references.' This was not consistently done. For example, one person gave a relative as the sole reference on the application form. A hand written note on the file stated, 'Three references sent off.' The registered manager was unable to tell us who they had been sent to. Only one reference had been obtained.

The provider failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Each staff file contained proof of the person's identity, a photograph, job description and terms and conditions of employment. Criminal record checks with the Disclosure and Barring Service (DBS) were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people. When people had disclosed a criminal conviction, reprimand or caution the provider discussed this with the individual and risk assessed the situation before making a decision to employ them. A record of this was kept securely in the person's staff file.

At our previous inspection, the registered manager had not reported potential safeguarding incidents to the local authority or the Care Quality Commission. Incidents had occurred which had resulted in injuries to people. These had not been investigated and no further action had been taken to ensure people were safe. This had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, potential safeguarding incidents had now been reported to the local authority safeguarding team. However, the registered manager and provider had failed to notify us of these incidents, as required by law.

There were enough staff to keep people safe; however they did not always have the skills necessary to provide person centred care. Since our last inspection the registered manager had introduced an additional member of staff to be on shift during the day. This enabled more people to go out regularly. Staff rotas showed there were consistent numbers of staff on duty. Staff worked flexibly to cover emergency shortfalls, such as sickness. Staff supported people to go to day centres, other activities and medical appointments. The management team were available on an on-call basis outside office hours.

At our last inspection medicines were not managed safely. Staff signed people's medicines administration records (MARs) before administering medicines and did not always date when medicines with a shorter expiry date were opened. Some people were prescribed 'as and when' medicines for example for anxiety. People had not always received these medicines as prescribed. This was a breach of Regulation 12 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had been made and there were now appropriate arrangements in place for the obtaining, storing, recording, administering and disposing of prescribed medicines. Medicines were stored in a medicine trolley, locked in a secure room. The temperature was monitored to ensure it was not too low or too high to ensure medicines remained effective. Staff signed people's MARs after they had administered their medicines and MARs were completed fully and accurately, showing people received their medicines as and when they needed them. Liquid medicines were now dated when opened so staff knew how long they were safe to use.

The registered manager had implemented a new form to be completed each time a person's as and when medicine was administered. This meant when people had a seizure and required emergency medicine or medicine to help them remain calm there was a clear record of why it was administered and when. Staff were trained in how to manage medicines safely and were observed by senior staff a number of times administering medicines before being signed off as

The service was clean and the environment was safe. Staff carried out regular health and safety checks of the environment and equipment to make sure it was safe to use. Staff had received training in infection control and protective equipment was available to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

No one new had moved into the service since our last inspection. The registered manager and deputy manager had begun to review people and update people's care plans to show how their needs had changed. Although this work had begun, only nine of 16 people had been reviewed.

Staff had a lack of understanding regarding best practice when working with people with learning disabilities. Since our last inspection staff had completed training in person-centred care and challenging behaviour, but did not have any knowledge regarding person-centred planning (a way of helping a person to plan their life) and person-centred active support (a way of supporting people to be as independent as possible.) As such people's care was not planned and delivered in line with best practice. The registered manager told us they were unaware of models of support to encourage people to be as independent as possible, and staff told us they felt there was a discrepancy regarding different staff members approach to encouraging people to do things for themselves. Staff did things for people, rather than encouraging them to do it themselves.

New staff completed an induction when they begun working at the service. Although new staff were enrolled to complete the Care Certificate (the Care Certificate is an identified set of standards that social care workers adhere to in their daily working life) new staff were supporting people without having appropriate training. For example, some new staff who had not had a previous background in care had not completed any training about keeping people safe, mental capacity or infection control. Some people had complex needs and required staff support with most aspect of their lives. There was a risk they would not be able to tell staff if they felt unsafe or how they wanted their care to be delivered. Without essential training in safeguarding or mental capacity there was a risk these new staff may not support people effectively.
Staff received regular one to one supervision from a senior member of staff to discuss their performance and personal development. Although staff received supervision, due to the lack of knowledge of the registered and deputy manager they did not always provide person-centred care. For example, people's care plans stated there was a cleaner available at the service who cleaned people's rooms for them. There were no plans in place to support people to clean their rooms themselves. Additional supervision meetings were held when staff required further support. For example, when one person had passed away suddenly the registered manager met with individual staff to check on their well-being.

The provider and registered manager had failed to ensure staff were appropriately trained and competent to carry out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection people were not fully involved in making decisions about what they wanted to eat. At this inspection staff had introduced a picture board which allowed people to make choices between two different meals. On the day of the inspection people were shown pictures of different meals and were able to choose between them. People discussed menus in regular meetings with staff, and staff told us they used the pictures to help people to decide what they wanted on the regular menu. Although this had improved, people were still not supported to take part in food preparation and some people were prevented from

accessing the kitchen at any time.

People were able to choose where they ate their lunch. Some people chose to eat in their rooms and other people ate in the communal lounge and dining room. Some people had guidelines in place from a Speech and Language Therapist (SALT) regarding how their meals should be prepared, and these were followed. The food served looked and smelt appealing. Some people's meals had been pureed and this too looked appetising: different food items had been pureed separately. There was a calm atmosphere when people ate, and staff gave people the support they needed. Staff sat with one person and explained what they had for lunch, and supported them in a calm, unhurried manner.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At our last inspection the registered manager had applied for DoLS for people when their liberty was restricted, but had not informed the Care Quality Commission when these had been authorised. At this inspection, we had been notified of all DoLS which had been authorised.

When people had required medical procedures, but been unable to consent, staff had been involved in best interest meetings. Staff told us they understood the MCA and since our last inspection had been encouraging people to make more choices for themselves. Although some improvements had been made restrictive practices still existed, such as people not being able to access all areas of their home.

People received the support they needed to manage their healthcare needs. One person appeared unwell during the inspection and staff contacted a doctor. Referrals had been made to health care professionals such as physiotherapists and occupational therapists when people's needs had changed. Staff worked with other professionals to ensure people received the support the needed.

Since our last inspection some areas of the service had been re-painted. People had been involved in choosing the colours. The service was accessible and corridors were wide, so people were able to mobilise using a wheelchair with ease.

Inadequate

Is the service caring?

Our findings

At our last inspection, people did not always receive care and support in the way they preferred and were not enabled to understand their care and support options. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Previously, the language used to describe people was not always respectful. Staff described people as 'rude' and their behaviour as, 'acceptable' and 'unacceptable.' At this inspection we found that although staff had received training in person-centred care there were still instances where staff described or treated people in a disrespectful manner.

Staff had completed a document titled, 'What people say about me' for some people. Although some of the comments were respectful, including, 'affectionate' and 'cheeky' they had also written that one person was a, 'hoarder,' 'messy eater' and 'unhealthy eater.' No consideration had been given to these potentially disrespectful traits or how the person may feel about being described in this manner. We discussed this with the registered manager and deputy manager and they agreed they had not considered that these terms could be disrespectful.

Staff were not consistently respectful of people. Although we observed care staff spending time with people, listening to them and providing support, one member of domestic staff spent the day with earphones in. A person spoke to them and they walked by and ignored them. We discussed this issue with registered manager and they told us the staff member had been spoken with before about their use of headphones. They told us they, "Had not realised" the staff member was wearing them during the inspection.

At our previous inspection there was an open plan kitchen that was part of the dining room and lounge so the kitchen was open plan and did not have a door. People were not allowed to use the kitchen however, and there was a sign displayed which stated, 'Under no circumstances are non-members of staff permitted to use any kitchen appliances.' There were no plans in place to increase people's skills within the kitchen or to promote their independence. At this inspection, the sign had been removed and some people were able to go into the kitchen to return plates or cups that they had used. Other people were still not allowed to access the kitchen. One person asked a member of staff if they could help in the kitchen, and they were told, "You know you are not allowed in the kitchen it is too dangerous." No risk assessment had been completed regarding the person's access to the kitchen or consideration given to how the person could be supported to use the kitchen safely.

The registered manager and the provider had failed to ensure people were treated with respect and dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection communication was not supported. Information was not always provided to people in an accessible way, that was meaningful to them and the environment did not support communication. At this inspection a board with pictures of objects had been introduced by staff as an additional way of communicating with people and offering them choices. Staff used the board to show people pictures of different meal options and potential activities and people were able to make a choice between the two.

Staff were reminded during staff meetings to use this, particularly at mealtimes.

We asked the registered manager and deputy manager if they had sought advice from a specialist in communication, such as a speech and language therapist as to what may be the most appropriate tools to assist people with their communication. They told us they had looked information up on the internet and made their own decisions about what to implement. Neither were trained in specialist communication methods. Whilst the board was increasing people's opportunities to make their needs known, some people living at the service had profound needs and required specialist support to make their needs known.

The provider and registered manager had failed to ensure people received person-centred support regarding their communication needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some kind and caring interactions. When one person became distressed, staff went over to them and offered them reassurance. They knelt down and looked the person in the eye. They asked the person what was wrong, and if they needed anything. The person indicated that they wanted a cup of coffee and this was bought for them immediately.

When people needed additional support from an advocate, this was arranged. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Inadequate

Is the service responsive?

Our findings

At our last inspection people did not always receive person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Previously, staff did not always follow guidance provided by healthcare professionals. In one person's care plan we saw a speech and language therapy (SALT) report dated 27 April 2016. The speech and language therapist had recommended staff 'implement visual day planning' with one person. This was designed to ease the person's anxiety around going out and helped staff to plan with the person their activities for the day. Staff had not implemented the visual day plan for the person and the registered manager told us they had, 'Completely missed' this essential recommendation.

At this inspection, we asked to see the person's visual day plan. The registered manager told us they had decided the person did not need it, as staff had introduced a picture board to assist people with making choices between two different things. The SALT report had not been based on assisting the person making choices, but 'to support them to understand what is happening and help them with any changes or transitions.' There had been incidents when the person had become distressed and displayed behaviour that challenged. During the inspection, they did not engage in activities and instead chose to spend time on their own, in a quieter part of the service. The registered manager had not sought advice from SALT before making the decision to not implement the visual day plan.

People told us they would speak to the registered manager and staff if they had a concern. The provider had a complaints policy, which was displayed on the noticeboard in the service. An easy to read version of how to complain was available. The registered manager told us there had been no complaints received since our last inspection. Staff held regular residents meetings with people, and asked them if there was anything they would like to change, however, some people had complex needs and were unable to communicate verbally. Staff told us they knew people well, however due to their lack of knowledge regarding communication for people with profound needs, there was risk they would miss signs that were unhappy with their care.

At our last inspection some people rarely left the service, even though they liked to go out regularly. At this inspection, some improvements had been made. People were now engaged in activities and accessing the community. However, there was little engagement with people regarding what activities they would like to do. The registered manager had introduced an overview of trips out and outings so they were able to track who went out and when. These were analysed monthly to ensure that people were going out regularly. On the day of the inspection some people with complex needs went out with staff shopping, and for coffee. They returned from their trip smiling and appearing calm and content. Other people took part in a range of activities inside the service. One person chose to spend time on their own, in a quieter area of the service, but staff still spent time with them reading a book and chatting about what was happening that day.

At our previous inspection, people were not involved in developing and updating their care plans. People's care plans were not always person centred and some contained inaccurate information. Some people did not have any personal goals recorded. At this inspection, although some people's care plans had been updated we found a similar situation. One person's care plan, which had recently been updated, had a goal

which stated, 'To continue to behave in a more positive way and reduce incidents of negative behaviour.' Another person's goal stated, 'To reduce the frequency of shouting outbursts and increase polite communication.' However, there was no plan about how this was to be achieved. In order for people to develop new skills or maintain skills they have developed, it is important for them to have a plan with steps towards a goal. This ensures staff offer people the correct support towards their goals and do not do things for people which they could do themselves. Without clear plans people may not achieve their goals and develop skills to lead fulfilling, meaningful lives.

Staff told us they felt that there was an inconsistent approach to assisting people to be as independent as possible. One staff member told us, "I would say it depends on the staff member and the particular person. It can be difficult if you are encouraging people and other staff members do things for them. [One person] always asks us to peel an orange. I always say they should do it themselves but some staff do it for them."

The provider and registered manager had failed to ensure people received person-centred care. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not currently supporting people at the end of their lives. Some people had a plan in place regarding what they wanted to happen when they died, however this had not been put in place for everyone. We discussed this with the registered manager and they agreed this was an area for improvement. A representative from the local District Partnership Group had visited people and discussed death and bereavement and used different methods of communication, such as pictures and books, to help people understand the topic.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found that the provider lacked oversight of the service and the registered manager lacked the skills and knowledge to carry out their role effectively. We found multiple breaches of the health and social care act and issued a warning notice relating to Safe Care and Treatment. We required the provider to become compliant with regulation 12 by 10 November 2017. We issued requirement notices relating to good governance, safeguarding, person-centred care and a need to notify CQC of important events that happened within the service. We also placed a condition on the provider's registration, requiring them to send us monthly updates on the service, some of these had been received. At this inspection, we found ongoing concerns and required improvements had not been made.

The registered manager and deputy manager worked at the service each day. However, there was no sense of leadership and direction. Actions that needed to be taken as a result of the last inspection had not been completed. For example, only nine people's care plans had been reviewed, updated and re-written. There was no clear action plan to show what needed to be completed, by whom and by when. The registered manager had failed to implement recommendations from a speech and language therapist.

Regular checks and audits were carried out to check on the quality of service. The registered manager completed a monthly report which gave a brief overview of the checks carried out. These included the environment, monitoring activities, feedback from people and staff, health and safety and fire safety. Monthly medicines audits were completed and staff were observed during medicines rounds to check their competency. Although these checks were occurring they had failed to identify the issues regarding risk management and person-centred care that we discovered at this inspection.

The providers lacked oversight of the service. The registered manager told us they did not receive any form of supervision, and the providers did not complete any formal checks on the service. One of the providers regularly visited and worked at the service, but this was not in a management or oversight capacity. We asked the registered manager to send us information following the inspection, including the staff training matrix and statement of purpose. We did not receive this information. When we called the service, we were told the registered manager was on holiday. We asked if the providers had access to the information we required and were told, "Only the registered manager has access to these." Without access to essential information it would be impossible for the providers to have oversight of the service and ensure the necessary compliance.

The providers had failed to ensure the registered manager had the skills, knowledge and experience to lead effectively. The registered manager told us they did not receive any mentoring, coaching or supervision from the providers. Both the registered manager and deputy manager told us there were gaps in their knowledge regarding how to effectively manage a learning disability service. The registered manager told us, "We have learnt by doing. We have never worked in any other home." The deputy manager said, "I would like to be more knowledgeable."

At our previous inspection the registered manager did not have a plan to develop and maintain

their skills or keep up to date with good practice. They did not have a clear understanding of person centred planning or positive behaviour support which is best practice when supporting people with a learning disability. The registered manager did not currently attend local forums for registered managers or providers where they could hear about examples of good practice and share experiences. This was discussed with them and they agreed it would be beneficial for them to develop their knowledge further. At this inspection they told us they had attended training on 'challenging behaviour' and attended a conference on CQC's inspection methodology. However, they told us they had been 'too busy' to attend any events to share good practice or experiences. The provider was a member of the Kent Integrated Care Alliance (KICA) but neither the provider or registered manager had attended any of their events.

The provider's mission statement noted, 'Our ethos has always been to provide a high standard of service but also to create a homely atmosphere where the service users feel comfortable, respected, empowered and happy, regardless of their disability.' At our last inspection we found that staff did things for people, rather than with them. Although we found some improvements such as a picture board that had been introduced to help people choose between two different activities or foods there was still further scope to increase people's independence. People did not have goals in place and access to the kitchen in their home was restricted.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to respect and involve service users and had failed to maintain accurate and complete records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not truly understand their responsibilities with regards to running a regulated service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This ensures that CQC can then check that appropriate action had been taken. At our previous inspection the registered manager and provider had failed to notify us of important events including the authorisation of DoLS applications and potential incidents of abuse. At this inspection there were three incidents of potential abuse that had been reported to the local authority. The registered manager had again not notified us of these incidents. We asked why and they told us, "I did not know I had to notify you of that", even though this had been an issue at the last inspection. We asked them to submit these notifications as a matter of urgency, but these had still not been received at the time of the report.

The provider and registered manager had failed to notify CQC of notifiable events in a timely manner. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had worked with the local safeguarding and commissioning teams. The safeguarding co-ordinator had visited the service and given all staff training on safeguarding. The local commissioning team had visited the service regularly since our last inspection. They were monitoring the service and working with them to try and bring about improvements.

There were monthly staff meetings. Staff told us they were able to express their views and opinions openly. People met each month and discussed their views and ideas about activities, planned holidays and to introduce new members of staff. Annual surveys were used to obtain the views of people, relatives, health care professionals and staff. These were due to be sent and the registered manager told us the feedback would be analysed when received to help improve the quality of service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had failed to notify CQC of notifiable events in a timely manner.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to ensure people received person-centred care.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider and registered manager had failed to ensure people were treated with respect and dignity.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to ensure that staff had the necessary guidance in place to keep people safe.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to respect and involve service users and had failed to maintain accurate and complete records.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to ensure staff were appropriately trained and competent to carry out their roles.

The enforcement action we took:

We cancelled the provider's registration for this location.