Normanshire Care Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Normanshire Care Services is a residential care home providing personal and nursing care to five people with learning disabilities aged 25 and over at the time of the inspection. The service can support up to six people in one adapted building.

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

People's experience of using this service and what we found
People's safety had been compromised. The provider failed to ensure people were safe and safeguarded from possible abuse. We found evidence to substantiate concerns raised in relation to the care provided to people. These concerns included failure to meet people's nutritional and health needs, failure to ensure people received care according to their needs and insufficient staffing levels to meet people's individual needs.

People were supported by staff who had not received appropriate training to effectively carry out their role.

Recording of PRN ('as and when required') medicines, such as paracetamol and topical creams, required improvements. We made a recommendation in relation to medicine management.

The provider had not always worked with professionals to seek advice or share information about people's health conditions. We found opportunities had been missed where the involvement of a health or care professional would have benefitted people.

Care plans were written in a person-centred way and detailed people's likes and dislikes. People's communication needs were documented in their care plan. However, information in care plans was not always accurate. During our visit we observed staff spoke in a caring and kind manner to people. Staff spoke passionately about people and the care they provided. However, we found care was not always delivered to people in line with their plan of care. We received mixed feedback from relatives about the care their relative received. People were not always treated with dignity and respect.

The service did not apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as a possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support. People did not always have the

appropriate support to give them choice and control and people's independence was not always promoted.

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

Governance arrangements at the service were poor. Systems for monitoring the quality of the service were not effective and did not highlight the concerns found during our inspection.

The provider was not aware of their responsibilities under Duty of Candour and failed to report notifiable incidents to the CQC.

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

Rating at last inspection
The last rating for this service was Good (published 5 January 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines, staffing, management of the service and the quality of care. This inspection examined those risks.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring, Responsive and Well-Led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Normanshire Care Services on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people receiving safe care and treatment, person-centred care, safeguarding people from improper treatment or abuse, staffing and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below

Inadequate

Is the service effective?

The service was not always Effective.

Details are in our effective findings below

Requires Improvement

Is the service caring?

The service was not always Caring.

Details are in our caring findings below

Requires Improvement

Is the service responsive?

The service was not always Responsive.

Details are in our responsive findings below

Requires Improvement

Is the service well-led?

The service was not Well-Led.

Details are in our well led findings below

Inadequate

Normanshire Care Services Ltd

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by an inspector and inspection manager.

Service and service type
Normanshire Care Services is a 'care home' for people with severe learning disabilities, most of whom are non-verbal. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home accommodates a maximum of six people. At the time of our inspection there were five people living at the home.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection

People using the service had complex needs, most of whom were non-verbal. During the inspection, as people using the service were often not present or were being supported in their rooms, we were not able to observe care to help us understand the experience of people who could not talk to us.

We spoke with two relatives about their experience of the care provided. We spoke with six staff including the registered manager, four support workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and associated risk assessments and monitoring tools. We looked at 26 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further documentation related to recruitment, staff supervision, health and safety and risk management. We spoke with the local authority and a health and care professional.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
http://crmlive/epublicsector_oui_enu/images/oui_icons/cqc-expand-icon.png

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

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

Systems and processes to safeguard people from the risk of abuse
- Systems and processes were not effective in safeguarding people who used the service from abuse.
- During our inspection we found body maps for one person indicated that they had sustained bruising and scratches in different areas of their body. The registered manager told us the person was prone to bruising as they had thin skin and the procedure was for staff to report this to one of the managers. He told us he had verbally spoken with the staff member to remind them to record the outcomes, but these discussions had not been recorded, and no further action was taken by the registered manager. Therefore, we could not verify appropriate action had been taken. The registered manager told us this had been reported to the local authority, but this could not be confirmed.
- New staff had not been trained in safeguarding people, therefore were not aware of the actions to take should they suspect abuse.
- Training records showed existing staff had recently completed training in safeguarding people. However, this had not been effective in ensuring staff understood how to safeguard people and their responsibility in terms of the whistleblowing policy and the external authorities to report to should their concerns go unheard by the service. This put people at risk of harm. Some staff told us they were unaware of the procedures to follow.
- The provider's nominated individual told us there had not been any safeguarding concerns since our last inspection. This was incorrect as we found evidence of at least one incident that should have been reported and investigated.
- Relatives gave mixed feedback on whether they felt their relative was safe at the home. One relative told us. "Absolutely not, [relative] doesn't have [the right number of staff caring for them] and other people are allowed to walk in and out of his room." Another relative said they felt their relative was safe.

We found people were placed at risk of harm. This was a breach of regulation 13 (Safeguarding People from Improper Treatment or Abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;

- The provider failed to assess the risks to the health and safety of people receiving care.
- For example, the risk assessment for one person clearly stated, 'there is the potential risk of [person] drinking dangerous substances (regulated under the control of substances hazardous to health (COSHH)

regulations) or toiletries.'
● However, the provider failed to manage the risk, and had not followed COSHH Regulations by appropriately storing COSHH items. We found COSHH products were left in an unlockable cabinet in the bathroom used by the person and accessible to them. This put the person at risk of harm by consuming hazardous substances. These were immediately removed by the provider who told us these should not be there.
● People were put at risk of harm because the provider failed to assess the risks related to the premises when carrying out refurbishments to extend the office in the garden area.
● We observed tools left in the garden which put people at risk of injury. Despite requesting information from the registered manager on how these risks would be managed to keep people safe, this was not provided.
● We received mixed feedback from relatives. One relative told us on one occasion they had visited their relative and found boiling water on the cooker with no care staff around as they were busy with cleaning tasks. This put people who used the service at risk of harm and scalding. Following the inspection, the provider strongly denied this incident had taken place.
● We observed this to be the case during our inspection. We noted one staff member had left the person they were caring for to carry out laundry tasks. This was confirmed by staff who told us they were required to carry out domestic tasks whilst providing care to people and often unable to give people the one to one care they need. This put people at risk of harm.
● Personal evacuation plans were generic and did not take into account people's individual needs according to their plan of care.
● During our inspection the provider confirmed the London Fire Brigade (LFB) inspected the service on 7 July 2019. They were awaiting the report but stated the LFB had not highlighted any concerns.
● We subsequently received a copy of the LFB report which clearly showed there were a number of issues with fire safety at the home. This compromised the health and safety of people living at the home and put them at risk of harm in the event of a fire.

We found people were placed at risk of harm as risk to people were not appropriately assessed or managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risk assessments covered areas such as incontinence, choking and eating and drinking. Some of these covered areas of risk, possible harm and control measures for staff to follow.
● Each person had a behavioural plan in place which provided staff with guidance on how to manage behaviours which challenged the service.
● Records showed that one person worked with the local authority behaviour specialist to help the service to better understand their needs and condition, which was still under review.
●This was confirmed by the behaviour specialist who told us they had visited the service to assess the person and observed some good interactions between staff and the person who they seem to know well. The specialist had yet to confirm whether recommendations made had been completed.

Staffing and recruitment
● Staffing levels were not adequate to meet people's needs.
● Our inspection was prompted in part due to concerns regarding staffing levels. Each person required either one or two staff to care for them during the day or night. Two people each required two staff to support them whilst in the community.
● During our inspection we observed one person was unable to go out in to the community, in line with their activity plan, as staff were not available to take them out.

● A relative told us staffing levels were not sufficient to meet their relative's needs. They had visited their relative and found two staff members taking care of four people.
● We found further evidence of poor staffing levels. Fire drill records showed the number of staff on duty (at the time of the fire drills) was not sufficient to meet people's needs. The registered manager told us these documents were incorrect as some people attended day centres or went out in the community, so the number of people in the home at the time of the drills was fewer than records indicated.
● We reviewed the staffing rosters for July, August and September 2019 and found some staff worked excessive hours at the service and other services owned/managed by the provider. This put people at risk of harm as staff were unable effectively care for people due to the excessive working hours. For example, one staff member was on the rota for this service and had worked 56 hours Monday to Friday. At the same time, they were on the rota for another service managed by them and had worked 16 hours over four days. This meant the staff member had worked 72 hours in one week at two different services.
● Two other staff members were on the rota for August 2019 to work at this service as well as being on the rota for another service run by the provider, working 8.00am to 8.00pm, followed by a waking night shift. This meant the staff members worked a 12 hour day shift followed by a 12 hour waking night shift, a total of 24 consecutive hours. This is not appropriate, particularly when providing support to people with complex needs
● Staff told us they were required to carry out domestic tasks as well as looking after people who used the service. During our visit we noted one staff member had left the person they were providing one to one care to, to carry out domestic tasks. This was not in accordance with their plan of care. This put the person at risk of harm.
● The above-mentioned concerns meant people's needs were not met in line with their plan of care and therefore put them at risk of harm due to insufficient staffing levels.
● The provider told us staffing levels were based on people's individual package of care as agreed with the local authority. We found this was not the case.

We found people were placed at risk of harm as staffing levels were insufficient to meet their needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safer recruitment practices were not always followed. Staff files reviewed showed gaps in relation to references, employment history and evidence of the right to work in the UK.
● For example, one staff member had arrived in the UK two weeks prior to working with the service. They had been employed without the necessary recruitment checks being carried out, such as appropriate references, application form and criminal record check. This put people at risk as the provider could not be assured that the person was safe to work with people who used the service. On the third day of our inspection, the registered manager told us this person had been taken off the rota pending all the necessary checks being in place.
● For another staff member, their resident permit had expired on 13 November 2018. We acknowledge you sent us a copy of the new permit on 3 September 2019. You were unable to send us a copy of the initial permit as you stated this had been destroyed. This meant you had no evidence that this member of staff had always had the right to work in the UK.
● Records for two other staff members did not contain information on the reasons for gaps in employment. For example, one file stated a full employment history had been given but this was inaccurate. The application form only stated the staff member had had two jobs between January and April, without stating which year this related to. This evidence supports our judgement.

We found people were placed at risk of harm as safe recruitment practices were not followed (Fit and proper persons employed). This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Using medicines safely
● Not all medicines were safely and appropriately managed.
● PRN protocols for 'as and when required' medicines were in place. We made the registered manager aware of gaps related to recording of PRN medicines and application of topical creams. As these were not always recorded we could not verify that these had been given as prescribed.
● Systems in place for managing medicines included a medicine management policy and procedure.
● Medicines were stored safely in a locked cabinet. Each person had a medicine profile, which included a medicine health overview.
● We observed one person was unable to use a specific antibiotic as it had a detrimental effect on their potassium levels. This had been clearly highlighted as a potential danger in their medicine records.
● Systems were in place for managing controlled drugs. A controlled drugs register was in place and two staff had signed when these had been administered or checked.
● Medicine administration record (MAR) charts for regularly prescribed medicines were appropriately completed.

We recommend the provider seeks advice and guidance from a reputable source in relation to PRN and topical creams medicine management in care homes.

Preventing and controlling infection
● Safe infection control practices were not always followed.
● Records showed staff were provided with infection control training and some staff confirmed this. However, staff told us people's clothes were washed together with soiled clothing. This put people at risk of harm and acquiring an infection.
● The registered manager told us he was not aware of this, and he would address it with staff.

We found people were placed at risk of harm and acquiring an infection as the provider failed to follow good infection control practice. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
●There was limited opportunity to identify where lessons could be learned, such as through accidents and incidents. For example, where staff identified an injury there was no evidence of the service exploring what could be done to prevent a reoccurrence.
●The registered manager told us all incidents were discussed verbally with staff, but this was not recorded. Therefore, we could not be confident that learning from incidents had occurred.
● Staff told us they completed an incident form and reported any incident to the manager on duty, usually the registered manager or deputy manager.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before joining the service. This was confirmed by a relative who told us, "Yes, an assessment was completed and included all his needs. The local authority was involved and developed this with the provider."
- People had individualised care plans which documented their preferences for care, likes and dislikes and choices.
- However, the service had not utilised national standards and guidance to inform the care practices in the home. For example, the service failed to demonstrate the principles and values which underpin CQC guidance Registering the Right Support.
- People did not always receive person-centred care in line with their plan of care.
- For example, one person did not have their needs met in accordance with their pre-assessment and personal behaviour support plan. This stated the person should be supported on a one to one basis by confident male staff.
- During our inspection we observed this person being supported by a female staff member. Rosters reviewed also showed this person had repeatedly been looked after by female staff. This was confirmed by staff during our inspection. This meant the person's assessed needs were not being met in line with standards, guidance and the law and the provider failed in their duty to protect female staff from possible harm.
- We asked the provider's nominated individual why they allocated female staff to work one to one with the person knowing female staff were being put at risk. The registered manager told us this behaviour was in the past and was not a current issue.

We found no evidence that people had been harmed, however, the care and treatment of people did not always meet their needs. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff were not always sufficiently supported to effectively carry out their role.
- Not all staff were appropriately trained to deliver the specialist care required to meet people's needs in relation to their learning disabilities, autism and behaviours that challenged the service. People living at the

home had complex needs and required staff with the right skills and knowledge to effectively care for them. This meant people were supported by staff without the right skills to effectively care for them.

● Staff told us they would benefit from training in areas such as learning disabilities and autism to help them to understand the needs of the people they cared for. A staff member told us, "I really need training, not just medication, people are really, really challenging, I really think I need the training. I don't have any experience in this area."

● We received mixed feedback from relatives about staff skills and experience in providing care. One relative told us they felt staff were skilled in providing the care their relative required. Another relative felt some staff were, "Unqualified and not trained. Therefore, not able to provide the care people needed."

We found people were placed at risk of harm as staff were not trained and supported to effectively carryout their role. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff induction consisted of new staff shadowing more experienced staff for two days, including reading people's care plans and risk assessments. During our inspection we saw a new staff member reading through people's care plans as part of their induction to the service.

● The provider's nominated individual told us staff supervision took place every two months, or more frequently if this was required. Records showed some staff had completed a yearly appraisal. Following our inspection, the registered manager sent us a supervision and appraisal matrix which showed dates staff had or were due to complete these.

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

● Daily records showed some people were supported to maintain a balanced diet however this was not always with food of their choice.

● We received mixed feedback from relatives about the food and people's choices. One felt their relative had food they liked. Another told us their relative did not always have food of their choice due to budget constraints.

● Staff knew people's likes and dislikes for food and often prepared food of their choice.

● The provider's nominated individual told us there was no set budget for food and it was dependent on what people wanted.

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

● People's records showed some had input from other health and care professionals, such as the dietitian, GP, dentist and optician.

● However, the service had not always followed the recommendations of health and care professionals.

● For example, one person with special dietary needs was not referred back to the dietitian following fluctuating weight loss. Records showed the person had been weighed monthly and not weekly in line with professional advice. Daily records provided details of the person's food and drink intake, but these records were not monitored to ensure the person had eaten and drunk enough. This put the person's well-being at risk.

● A staff member expressed concerns about this person, "I have concerns about food. [Person] is very skinny, he has a plan, but they do not follow it." The registered manager told us the person's weight fluctuated. This was confirmed by the person's relative.

● We brought this to the attention of the registered manager. The following day the registered manager made an appointment with the person's GP regarding their weight loss.

Adapting service, design, decoration to meet people's needs

● The environment was not always suitable to meet people's needs.

● The home was generally clean, and some rooms had been personalised.

● However, recent building works had restricted people's use of the garden area and the activities room, which was being used as a temporary office area. This meant people's needs may not have been met due to refurbishment works, as they were restricted from using communal areas of the home.

● The registered manager told us people were still able to access the garden, however, he had not assessed the risks this posed whilst building work was underway.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Records showed that DoLS applications had been made and approved to restrict people of their liberty for their safety.

● We observed people had locks on their bedroom door. We asked the provider's nominated individual why people had locks on their doors, we were told for one person this was what their relative wanted and it was in the care plan. We did not find any information in relation to this lock in the care plan.

● The nominated individual then told us the locks were already in place when they took over the service. This meant we could not be confident that people were freely able to access their rooms as and when they wanted to.

● The registered manager told us people's relatives had the appropriate legal documents pertaining to deputyship authorised by the Court of Protection. Although this was documented in people's care plans, the provider had not seen copies of these. We noted one person's finances were managed by the local authority as their appointee.

● The deputy manager had completed a mental capacity assessment for each person who used the service, however, these were generic and had not taken into account people's individual mental health needs.

● Staff understood the need to ask people for their consent before providing care.

We recommend the provider seeks advice and guidance from a reputable source in relation to working within the requirements of the Mental Capacity Act (MCA) 2005.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

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

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

- Staff did their best to ensure people were well treated and supported. However, the care provided by them was significantly undermined by the failure of the provider and registered manager to ensure all staff were well trained to carry out their role.
- Relatives told us staff delivering care to people were caring. A relative told us, "Most of the staff are caring, they can only do their best under the conditions." For example, the relative mentioned the budget restrictions in place when staff did the weekly shopping for the house.
- We spoke with the provider's nominated individual about this, he told us there was not a budget and they bought whatever people wanted.
- Staff spoke in a caring manner about the people they supported and cared for. One staff member talked caringly about the importance of giving the person they were caring for space to calm down when this was needed. This was also recorded in the person's care plan. This showed staff respected the person's need for space.
- During our inspection we observed very little interaction between staff and people who used the service. On the three occasions when we visited the home people were either briefly visible in the home or taken to their room and stayed there for the duration of the inspection. The registered manager told us people had chosen to be in their rooms.
- The service had an equality and diversity policy. This provided guidance to staff on how to ensure people who used the service were treated in a fair and respectful manner.
- People had health action plans and hospital passports in place. This helped to ensure people's health needs were met. A hospital passport is a document that provides hospital staff with information about a person's health needs, as well as useful information such as interests, likes and dislikes and preferred method of communication.

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

- We received mixed views from relatives about the way people were involved in their care. Whilst one relative felt very much involved in their relative's care and had seen the care plan, another relative told us they were shown their relative's care plan some time ago but had not been involved since their relative moved in two years ago.
- The registered manager told us they gathered feedback from relatives and involved them in their relative's care. Records seen confirmed this.

Respecting and promoting people's privacy, dignity and independence

● Staff understood the importance of respecting people's privacy and dignity.

● We received mixed views from relatives. One relative told us, "Yes, I feel my relative is treated with dignity and respect." Another relative told us, "Yes, because some carers very caring, and no." This relative explained that their relative's toiletries and clothing were often used for other people who used the service.

● People's level of independence was recorded in their care plan. This provided information on the care people needed to maintain their independence and was confirmed by staff who gave us examples of how they supported people to maintain some independence, such as when assisting with personal care encouraging the person to do what they can themselves.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were person-centred and had been regularly reviewed. However, we found the service was not always responsive to people's needs despite this.
- Daily care records indicated people took part in activities detailed in their plan of care. However, this was in contrast with what relatives and staff told us. A relative told us their family member did not always participate in activities of their choice.
- We received mixed feedback from staff about people taking part in activities of their choice. A staff member told us there was a lack of activities for people, staff were not always engaging with people and staff were always busy cleaning or cooking for people. One staff told us "To be honest, there should be more [activities]."
- During our inspection we observed people stayed in their room. One person was in their room with two staff members for the whole time we were there, over three days. The daily activity plan for this person showed over a 38-day period the person had spent majority of their time either in the garden, playing a keyboard or with toys, watching TV or relaxing at the home.
- Another person did not take part in their chosen activities. As per their care plan and picture exchange communication system (PECS), they were due to go for a car ride on one of the days of our inspection. The deputy manager told us he could not go as she should be taking the person out but had a meeting to attend. The deputy manager made a decision to tell the person about the change of plan, even though the person's care plan stated staff should avoid sudden changes to the person routine, as they did not like changes.
- This meant care was not always planned and delivered in line with people's needs and well-being.

We found no evidence that people had been harmed however, the care and treatment of people did not always meet their needs. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Care plans documented people's preferred method of communication and provided additional information for staff.
● Examples of communication methods included objects of reference, Makaton signs and sign language.

Improving care quality in response to complaints or concerns
● The registered manager told there had been no complaints since our last inspection in 2016 but had systems in place should this be required. Records confirmed this.
● There was a complaint policy and procedure in place, including an easy read version which we saw displayed in the communal hallway of the home.
● A relative told us if they made a complaint to management, it was always blamed on staff. They said, "They never take responsibility, staff are reprimanded and threatened with the sack, either you do what you are told or are sacked." This was in contrast with what the registered manager told us, that there had not been any complaints.
● The registered manager told us, "Staff are trained in the complaints policy, whistleblowing and safeguarding. I am confident that staff would speak out if there is an issue."

End of life care and support
● No one at the home was currently receiving end of life care, however, the provider told us they had an end of life policy in place should this care be required.
● We noted end of life care forms were in people's care files. However, the registered manager told us people's end of life wishes had not been explored due to the age of the people living at the home.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

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

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

- The provider did not understand their responsibilities under Duty of Candour. The provider had failed to notify the CQC of a notifiable incident involving a person who used the service as required by law.
- Systems to monitor the service were ineffective and had failed to identify the concerns found during our inspection.
- People did not receive person-centred care that met their individual choices and needs.
- Risks related to people's health needs, care and treatment, safety and welfare were not assessed, monitored or mitigated.
- The provider failed to report possible abuse and ensure staff were trained to effectively understand their role and responsibilities in delivering care.
- Learning from incidents was not recorded, therefore we could not confirm whether improvements had been made following an incident.

- The provider failed to establish robust systems and processes to ensure people received quality care.

We found people were placed at risk of harm, systems for monitoring the quality of the service were ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems for monitoring the quality of the service were not effective in ensuring people received a good standard of care and treatment.
- The registered manager told us they carried out monthly audits. This covered areas such as medicines, health and safety, infection control and care records.
- The provider's nominated individual told us they reviewed all the quality assurance reports completed by

the registered manager. He told us managers met on a monthly basis to get feedback, discuss challenges and training and any up and coming events.

● The nominated individual told us they visited each service run by them daily and made themselves available to staff who could call at any time.

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

● The provider told us they obtained feedback from relatives and professionals where possible. Feedback forms were sent out annually, the most recent sent this year and the provider was waiting for these to be returned. Records showed that feedback received from one relative was positive.
● Relatives told us they had completed a questionnaire asking them their views about the service. However, one relative told us they felt their suggestion to have a sensory room/area in the activities room went unheard by the provider. This space had not been fully utilised by the service and was mainly used as storage. During our inspection the nominated individual told us of their plans to develop the activities room.

● Most people living at the home were non-verbal, however, the nominated individual told us they would be able to check whether people were happy through their behaviour. We saw no documented evidence to show the provider had observed people to assess this or involved them in feedback.
● The provider told us they had an open-door policy, this meant staff were able to approach them or the registered manager if they felt they needed help.
● Staff said they felt supported and able to approach all the managers. Comments from staff included, "They are very accommodating, they are giving me the support I need," and "They are doing a good job." Another staff member told us they felt management could be more organised. This was in relation to infection control practices not being followed.

Working in partnership with others
● The nominated individual told us they worked with eight London boroughs and had developed a productive relationship with each one. They attended provider forums and worked with other health professionals with whom they had worked for a number of years, developing good professional relationships.
● There was some evidence of the provider working in partnership with health professionals. For example, records showed the provider had worked with the occupational therapist to meet one person's health needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to deliver person-centred care to appropriately meet people's individual needs and preferences. Regulation 9 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people from the risk of abuse because systems and processes had not been established to ensure staff understood their responsibilities. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to effectively operate systems including to assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; maintain securely such other records as are necessary in relation to persons employed in the carrying on of the regulated activity and the management of the regulated activity, and seek and act on feedback from service users, their relatives and the staff.

Regulation 17(1)(2)(a)(b)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to ensure persons employed for the purposes of carrying on a regulated activity must be of good character, to establish and operate recruitment procedures effectively, and the information must be available in relation to each person employed as specified in Schedule 3. Regulation 19(1)(a)(2)(a)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to ensure staff were suitably qualified, competent, skilled, experienced and appropriately deployed. This put people at risk of harm.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure people received care in a consistently safe way. This included failure to assessing the risks to the health and safety of service users of receiving the care or treatment, doing all that is reasonably practicable to mitigate any such risks, ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way, and assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12(1)(2)(a)(b)(d)(h)

The enforcement action we took:

We served the provider with the warning notice.