Complete Care Services Limited

Quince House

Inspection report

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23 September 2019

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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
Quince House accommodates six people with learning difficulty in one adapted building. At the time of our inspection five people were living at Quince House.

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

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

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons lack of choice and control, limited independence, limited inclusion. People were not supported to develop independence, access the community and express their choices.

People were exposed to risk of harm in case of fire because the provider failed to ensure they appropriately assessed the risk of a fire and completed actions in a timely way to ensure appropriate fire protection and detection was in place. Fire Marshall training was not provided for staff responsible for running a shift in the home although this is required by

Risk assessments were not always developed and individualised for people without giving staff specific guidance in how to mitigate risks and keep people safe.

People were not always protected from the risk of infections as the environment was not well maintained and in high risk areas like the kitchen the floor and kitchen units had not been replaced when damaged.

People were at risk of social isolation because there were not enough staff employed. Funded one to one support was not always provided to people, people`s holiday was cancelled. Arrangements were not in place to ensure people could access the community and engage in meaningful activities.

Care plans were developed, however these were not effectively reviewed to evaluate if people achieved positive outcomes. Positive behaviour plans were not developed to fully address areas where people needed staff`s support to prevent behaviours that challenged them and others.

Processes to learn lessons when incidents or mistakes happened were not embedded within the culture of the staff team. Where incidents had occurred within the service, these had been documented within the care records but then not discussed as a team or reported to safeguarding authorities.

Staff were not offered opportunities to further develop. Champions roles were being developed within the service which would enable staff to have additional training in a specific area, such as safeguarding, mental capacity or learning disability. The training for these roles were all occupied by only one member of staff.

Governance and performance management was not always reliable and effective. There was a lack of clarity around the governance arrangements and authority to make decisions. The registered manager had no delegated responsibility from the provider to make decisions where a cost was involved. This had to be approved and arranged by the provider and some actions were outstanding since 2018.

Governance systems were not developed or used effectively to identify and improve the concerns we found in this inspection. The provider failed to ensure appropriate management arrangements were in place when the registered manager was absent for more than 28 days from the service.

Following the inspection, we reported our concerns to the Local Fire Service, Environmental Health and the Local Authority and Clinical Commissioning Group.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 October 2018). After this inspection we met with the provider to discuss what they were planning to do to improve. The provider completed an action plan after the last inspection to show what they would do and by when to improve. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received from the Local Authority about the lack of appropriate care and support people received. Concerns about people`s dietary needs not being met, and people not being supported to access the community due to lack of staff. A decision was made for us to inspect and examine those risks.

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

Enforcement
We have identified breaches at this inspection in relation to safe care and treatment, staffing, person centred care, consent to care, safeguarding, environment and equipment, governance, and not submitting notifications for incidents in a timely manner.

For requirement actions of enforcement which we are able to publish at the time of the report being

published:

Please see the action we have told the provider to take at the end of this report.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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**

Quince House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Quince House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service 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 and was carried out on 11, 20 and 23 September 2019.

What we did before the inspection
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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke two members of staff, an agency staff member, the deputy manager and the registered manager. 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.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with a relative and social care professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

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

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

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People were not protected from the risk of fire. Hertfordshire Fire & Rescue service recommended for the provider to change the door to the laundry and boiler room with a specific fire door fitted with a self-closer. A further fire audit commissioned by the provider In August 2019 made the same recommendation. This meant that the provider failed to take any action and mitigate the risk to people in case of a fire for over two years.
- On the first day of the inspection there was no heat detector in the kitchen linked to the fire alarm system. This had been removed due to a leak on 18 April 2019. There was no fire detection in place for a high-risk area from 18 April 2019 until 30 July 2019. In July 2019 the local authority requested for the provider to put a temporary heat detector in place until the main one could be re-installed. This meant that for a period of five months people were at risk of harm due to not having a functional early fire detection in place. The provider refitted the main heat detector after the first day of the inspection, after we asked the Local Fire service to carry out an urgent visit.
- The provider arranged for the heat detector in the kitchen to be reconnected after the inspection, however, the fire door to the laundry and fitting smoke seals were still outstanding actions.
- The Regulatory Reform (Fire Safety) Order 2005 made it a legal requirement for services to have designated Fire Marshalls (fire wardens). At the time of the inspection none of the staff employed by the provider to manage and work in Quince House had Fire Marshall training. This had been booked following our inspection.
- Risk assessments were not personalised and developed for each identified risk. For example, a person`s mobility care plan detailed that they were at risk of falls due to seizures. There was no falls risk assessment in place to tell staff how to mitigate the risk of falls or what measures were in place to mitigate the risk of injury to the person. The person had a fall on 26 June 2019 and 19 September 2019 and sustained injuries both times. However, none of the falls triggered a review of their care plan to develop a falls risk assessment.
- People had choking risk assessments in place. These risk assessments gave insufficient guidance about how to mitigate the risk of choking, they were not personalised, and six control measures listed on the risk assessments were the same for each person. For example, `staff to receive regular in-house and external training in Basic First Aid`, `staff to receive training in managing challenging behaviour`. It was not clear how staff receiving this training topics would help them support people safely. The risk assessments did not detail if staff had to remain with people whilst they were eating, if the food had to be at certain consistency or what actions they had to take if people were choking.
- People were not protected from the risk of infections. The floor and the units in the kitchen were significantly damaged and could not have been cleaned effectively.

● People`s care records evidenced that they often developed sore skin and irritation. The lack of appropriate infection control measures increased people's risk of this.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people`s well-being were not sufficiently mitigated to protected them from harm.

Staffing and recruitment
● The provider failed to ensure that there were enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs, including their social and emotional needs. In August 2019 the registered manager was absent from the service. The deputy manager had been made responsible by the provider to manage the home in addition to them being on the rota to support people as well as attending training.
● People were at risk of social isolation and disengagement. Staff cancelled people's holidays because there were not enough permanently employed staff members to ensure people`s needs could be met safely whilst on holiday. No alternative arrangements were made following cancellation. Staff told us there were not enough staff employed and agency staff were used to cover for the any shortage.
● This led to people not receiving always receiving their allocated one to one time that they had been assessed as needing and not having support to go out to social or leisure or other activities in their local community. For example, two people only went out four times from the beginning of August to 11 September 2019. This meant that, the provider had not ensured there was sufficient staff to provide people with support to be part of their community or to engage in meaningful activities.
● Recruitment checks were in place to ensure staff employed were sufficiently skilled and experienced to work with people safely. Prior to staff starting work, a range of checks were completed. These checks included identity and right to work, criminal records checks, and references from previous employment. However, we found that references had not always been sought from previous employers and when received had not been verified.

We found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not enough staff employed to meet people`s needs.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider failed to ensure that the safeguarding policy and procedure in place was known and followed by staff. Not every staff member we spoke with knew what safeguarding meant.
● Following concerns raised by a whistle-blower in July 2019 there were five safeguarding alerts raised by the Local Authority. Staff we spoken with were unaware of the recent concerns raised and the findings from safeguarding meetings. When asked if they were aware they replied, "I don't know what's going on, they don't tell me, and I don't want to know I just get on with my job." This showed that any lessons learnt or measures to reduce the risks of further harm to people had not been shared with staff.
● The provider`s own systems and processes had not identified that a person`s specialist dietary requirements were not always met by staff. This had caused them pain and discomfort and requiring them to be seen by their GP. This had been identified by the safeguarding investigation done by the Local Authority. The registered manager and the provider were not effectively checking that people were receiving care in a safe way.
● People paid for a holiday to go away supported by staff. The deputy manager had to cancel this holiday because of lack of staff to support people safely. The holiday resort refused to re-fund the money people paid. This had not been raised as a safeguarding concern by the provider despite the risk that people were

exposed to financial abuse. The provider told us they were planning to refund people, however, at the time of the inspection people had not received their money back.

● Some people had behaviours which could challenge them or others. Incidents of these behaviours were recorded, however not reported to external safeguarding authorities and care plans were not reviewed to ensure further measures were considered to safeguard people. For example, staff recorded harmful behaviour a person had towards themselves but not followed the guidance from external health professionals to analyse for trends and patterns so that further protective measures could be implemented.

● Processes to learn lessons when incidents or mistakes happened were not embedded within the culture of the staff team. Where incidents had occurred within the service, these had been documented within the care records but then not discussed with the staff team. Minutes of team meetings did not record discussions in relation to lessons learned.

We found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because safeguarding systems and processes were not used effectively to protect people from the risk of harm.

Using medicines safely

● People received their medicines as the prescriber intended. Staff administering medicines had received appropriate training, and their competency had recently been assessed.

● Medication administration records (MAR) were complete with no gaps or omissions. However, we found that although stocks of medicines were correct, the stock record on the MAR did not tally with what people had been administered. The deputy manager agreed that this was an administrative error and they would speak with staff to understand why they had not physically counted the stocks of medicines.

● One-page profiles were in place that described people's diagnosis, the medicines taken and allergies. However, these records lacked person centred detail to inform staff about how people liked to take their medicines.

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 requires improvement. At this inspection this key question has remained the same.

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

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

- The environment had not been well maintained. We observed melamine peeling from kitchen cupboards. The floor in the kitchen was damaged and had come away, leaving a large hole in the front of the fridge. This was a trip hazard as well as an infection control risk. The walls in the communal areas were damaged, marked and scratched.
- Some effort has been made in the dining room with a colourful collage of people`s activities, and a dignity tree had been decorated. However, the lounge had two sofas with worn throws over them to mask the worn condition and holes in the furniture.
- In December 2018 the provider identified all the above issues when they carried out their service audit. However, at the time of the inspection all of the issues were still outstanding without a clear time frame of when these would be completed.
- In March 2019 the Local Authority contract monitoring team carried out a visit at the home. They identified the same issues and asked the provider to set an acceptable time frame to complete the work. The provider stated 2020 as an acceptable time frame for the work to be completed. However, this meant that people lived in an environment which did not promote their dignity and safety for more than two years.
- Communal areas in the home were stained and looked unclean. The environment was bare and did not promote comfort and warmth for people.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure that the environment was properly maintained.

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.

● Staff carried out mental capacity assessments for specific decisions, such as if the person wanted to live in Quince House, or not being able to leave. DoLS applications were made to the local authority to ensure that the restrictions applied to people`s freedom were lawful.

● Staff had not developed care plans to demonstrate how they were considering and applying the least restrictive care practices when supporting people. Some people had been assessed needing constant supervision and support when bathing or using the toilet. There were no guidelines for staff and no care plan to describe how staff could support people and still promote their right to privacy.

● Some people were assessed as needing two staff to go out in the community. Because the service had not employed sufficient staff these people had not been supported to go out in the last two months. This had not been risk assessed or considered as possible unlawful deprivation of liberty.

● People paid for a holiday to go away together with staff. However, no mental capacity assessments or best interest decisions were in place for people who had nobody legally appointed to make this decision for them.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not able to demonstrate that they always followed the MCA principles and acted in people`s best interest where they lacked capacity to consent to the care they received.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

● People`s needs were assessed and documented in their care plans. However, the guidance was not effective in terms of telling staff how to meet people`s needs. For example, a care plan instructed staff to encourage a person to go for walks, however it did not describe what and how to encourage a person whose verbal communication and understanding was limited. This person was not supported by staff to go for walks.

● People`s support needs and their care plans were not evaluated effectively. For example, where people needed staff support and encouragement to go out and use public transport there was no evaluation or update to review whether people achieved this.

● When assessing and planning support for people, staff had not always adhered to the principles and values of Registering the Right Support. There was a lack of planned outcomes for people, limited support to promote people`s choice, independence and inclusion in the community.

● People had additional support from specialist health care professionals. For example, psychologists, speech and language therapists, dieticians, behaviour support specialists and others. Guidance drawn up by these professionals was not incorporated in people`s care plans and often not used by staff.

● For example, a person had been assessed by a health professional in 2017. The report made recommendations for the approach staff should have towards the person to prevent them displaying challenging behaviour towards themselves and others. The recommendations had not been incorporated in the person`s behaviour support guidelines and a positive behaviour support plan had not been developed. This meant that staff had not had appropriate guidance in place to respond to this person`s behaviour as recommended by a specialist.

Staff support: induction, training, skills and experience

● Staff received regular supervision where they were able to discuss their performance, any potential issues, and seek support from their line manager. We discussed with the deputy manager the need to ensure that

discussions around staff development needed to have actions in place that were time specific and regularly reviewed.

● Although staff received training in areas such as safeguarding, health and safety and medicines administration we identified concerns which showed a lack of staff knowledge in these areas. Also, staff did not receive training in key areas to support people's identified needs. For example, staff had not received training in areas such as autism, and care planning.

● Staff were not offered opportunities to further develop. Champions roles were being developed within the service however, where these roles were in place these were all allocated to the deputy manager. This meant other staff did not have opportunities to develop in these areas.

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

● People could not give us feedback about the quality of the meals. There was a lack of fresh foods available in the fridge and freezer on the day of the inspection. The freezer contained ready meals. Menus demonstrated people were provided with choice but did not whether meals were freshly cooked or ready meals.

● Staff told us they prepared meals with some people and had take-aways which people liked.

● People's nutritional care records were not always kept up to date. One person`s care plan showed that they were losing weight, they had been referred to the GP and had nutritional drinks to help with this. Staff told us this was no longer the case and the person ate a normal diet, however this had not been documented in the care plan.

● People`s food likes, and dislikes were recorded, however there was no evidence that staff took these into consideration when creating the menus.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to attend their annual health appointments or other appointments they had.

● Staff liaised with appropriate health and social care services if they felt there was a change in people`s condition. For example, we saw evidence where staff had raised concerns regarding one person's health, resulting in a GP appointment and medicine being prescribed. This demonstrated staff ensured people had access to other professionals when required.

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 requires improvement. At this inspection this key question remained the same.

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; Respecting and promoting people's privacy, dignity and independence

- The provider`s systems and processes were not enabling staff to provide care and support to people in a non-discriminatory way.
- Some people relied solely on staff to support them to go out and support them to participate in meaningful activities. These people had limited opportunities to socialise, develop relationships and live fulfilling lives.
- The provider had not made arrangements for finding appropriate transport for people to go out within the community although people received funds for this service.
- There was a minibus available which belonged to the provider. However, there was no staff member able to drive this which meant that people who relied on this transport were not taken out. Assessments were not carried out to assess if people could use alternative transport like taxis, buses or trains.
- Staff addressed people with respect and patience. However, the feedback they gave about the environment people lived in demonstrated that they had low expectations about the standard of care people should receive in a care setting.
- We observed a person who had one to one support throughout the day. The deputy manager told us that the staff member providing one to one is expected to keep the person stimulated, offer drinks and snacks and do nice things throughout the day. Our observations did not support this expectation.
- The agency staff member was left with the person and were reading their care plan and had not engaged with the person. The radio was playing loudly in the home and no consideration was given if people liked this or not. Limited meaningful interaction was observed between staff and people.
- Staff told us they encouraged people to be independent by involving them in cooking and household tasks, however there was no evidence to support this. People`s goals and outcomes were not reviewed to monitor progress and there were no structured plans for staff to follow on how they had to support people to be independent.
- Staff had recorded `no change` when reviewing people's care and support plans for months and in some cases years. They made no records of what people achieved, what was tried to promote people`s independence and if it had positive results.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive care and support in a way to promote their dignity.

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

● There was little evidence in care plans and in our observations of how staff involved people in expressing their views.

● Most people had limited verbal communication and understanding. Some consent forms were signed by relatives of people without any indication of relatives having authority to sign on behalf of people. People`s likes and dislikes in some areas were documented like food preferences and social activities, however people were not supported to pursue these.

● How people liked their personal care delivered, any likes and dislikes which could improve their experience of the care they received were not explored.

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 requires improvement. At this inspection this key question remained the same.

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

- We found that the provider's systems and processes had not ensured that people received care and support in a personalised way. People received care in a task led way. Care was not always based on individual wishes, needs and choices. Records regarding the care and support provided were not descriptive of how and what support people needed from staff.
- People were not supported to go out in the community and engage in meaningful activities. People`s care plans detailed what activities they liked to do, however staff had not ensured that these were available for people to pursue. For example, a person`s care plan detailed that they liked dancing, eating out, playing with soft toys, listening to music and going to a youth club. The only available activities for this person were the soft toys and listening to music. They were not supported to go out in the community.
- Activities were not diverse or stimulating. Activity records evidenced that only a few activities were offered. A person`s relatives told us they were hoping for the person to move to a more suitable environment where activities were more stimulating, and they could socialise more.
- Activities were not evaluated or analysed to reflect if people were engaged and enjoyed them.
- Staff told us that not all the people living in the home had family living close by and had few visitors. People were not supported to attend clubs, social events or other activities where they could develop relationships with others.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive care and support in a personalised way.

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 contained information about people's individual communication needs. However, staff were not always able to use these communication systems.
- For example, a person`s care plan detailed that they had limited verbal communication. There was information for staff about the other ways they may communicate, such as by using objects of reference, pictures and Makaton signs. Throughout the day of the inspection we did not observe staff using any

communication aids. Staff told us, and it was confirmed by the deputy manager that staff were not trained and did not know how to use Makaton signs.

Improving care quality in response to complaints or concerns

● A complaints policy was in place for people and was in an easy read format. A complaints policy was available for visitors and relatives and was also prominently positioned within the home. There were no recorded complaints received since the previous inspection.

● Relatives told us they felt confident in raising concerns with management if there was a need for it.

End of life care and support

● There was no end of life care provided to people at the time of the inspection. We saw that staff contacted relatives to find out if there were any plans for the future when people would require this support. Staff had not received any training in this area.

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 requires improvement. 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

- A registered manager was in post but was absent from the service at the time of the inspection, we spoke to them on 23 September 2019. The deputy manager had assumed day to day responsibility in their absence.
- At the inspection visits on 11 and 20 September 2019 we found that the provider was not operating effective systems or processes to ensure compliance with the requirements of all the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a significant deterioration in the service provided to people in Quince House since the last inspection visit in 2018.
- The registered manager had been registered and worked at the home since 2011. The service has continually been rated as requiring improvement in the area of well-led in the last five inspection between 2014 and 2018. The provider was unable to evidence how they were adequately supporting the registered manager to bring about improvements needed to ensure people received safe and effective care.
- Audits carried out by the provider in December 2018 and April 2019 referred to needing to replace the kitchen cabinets, cracks in walls, and redecoration. There was no plan in place to address these issues and we found further areas in need of attention.
- We asked to see copies of audits undertaken at the service recently. The deputy manager gave us two audits that had been completed in relation to infection control and medicines. No other auditing had been completed in key areas such as care plans and recording, decisions and MCA and activity provision. They told us, "There is no routine reporting of staff vacancies, incidents, injuries, falls, complaints. These are picked up at the four months reviews only."
- People`s care was not planned or delivered well, and the provider did not have adequate oversight of this.

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

- Governance and performance management was not always reliable and effective. There was a lack of clarity around the governance arrangements and authority to make decisions. The registered manager had no delegated responsibility to make decisions. They told us they had no power of decision to address any issues which involved a budget. For example, decisions relating to maintenance were referred to the provider for action, servicing of the heating system, replacement of fire safety equipment and maintenance,

and replacement of furniture and kitchen areas. Some of these decisions had been ongoing since 2017 with no resolution and no action being taken.

● Staff were clear on their roles or accountabilities. However, there was a lack of systematic performance management of individual staff, or appropriate use of incentives to encourage staff to develop their skills and experience further. Staff were not kept aware of the service development and recent concerns raised to the local authority. Service development plans were not shared among staff for discussion. This did not demonstrate an inclusive environment where staff were encouraged to actively participate in the management of the service.

● Team meetings were regularly held with staff, which were led by the registered manager. Minutes of the meetings recorded discussions held regarding people's needs, such as health, finance and behaviour. However, meeting minutes did not address actions arising from previous discussions. For example, staff discussed one person and the need for them to engage more with others. This was not reviewed at the subsequent meeting and the person continued to not engage. Staff were informed they must take people out as much as possible during the 'good weather.' This had not been reviewed and people had not been able to get out and about.

● The deputy manager spoke in a staff meeting about their role as dignity champion, they stressed to staff the importance of good practice around duty of care, equality and diversity and working in a person-centred way. However, they did not discuss with staff how they could support them to achieve this, what these areas looked like, and what their observations had been to prompt this discussion.

● Governance systems and audits were not regularly reviewed. Risks were not always identified or managed when known. We found that incidents that occurred were not always investigated by the registered manager. The provider commented in their December 2018 audit that no incidents had occurred since June 2018, and only one in their April 2019 audit. We found a number of records where people's behaviours were monitored due to an incident that the provider did not identify as a risk.

● There was no system in place that gave the provider continual oversight of emerging concerns or risks in the service.

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

● A recent satisfaction survey had been completed in May 2019 by an independent organisation. The deputy manager told us staff completed the responses for people living in Quince House. Staff had not sought an advocate to support people, seek relatives' views or any other professional who may have been objective and impartial.

● As a result, people's feedback about Quince House suggested that all five people felt the service was safe, effective, caring, responsive and well led, with no areas for improvement or development.

● Areas of improvement however were raised by relatives and care practitioners. Concerns included staff not fully understanding infection control, people not having access to healthcare and not always being treated in a dignified manner. Some felt people did not receive a good level of care.

● The registered manager and provider had reviewed this feedback, but not shared it with staff. They had not developed an action plan to address the issues.

Continuous learning and improving care

● There was no current strategy in place to share learning and strive to improve the service. There was no effective approach to monitoring, reviewing or plans in place to evidence any progress in improving the quality of the service.

● We asked for a copy of a shared action plan between the manager, staff and provider. We were told one had not been developed aside from the action plan from the local authority monitoring visit.

● Lessons were not leant by the provider and improvements were not made across all the services owned by

them. The provider operates three other residential care homes which were also rated as requires improvement. In each of the recent inspections in all four locations, the well led domain has been rated as requires improvement.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and good quality care for people.

● The provider failed to notify CQC of reportable incidents. There were five safeguarding alerts raised by the Local Authority following an unannounced visit on 25 July 2019. The provider failed to notify the Commission about any of these.

This is a breach of regulation 18 (1) of The Care Quality Commission (Registration) Regulations 2009.

● On 09 September 2019 the provider notified us that the registered manager was absent from the service for more than 28 days. They told us the first day of their absence had been 10 August 2019. The deputy manager told us the manager had been on absent from the service from 02 August 2019. This was confirmed by the registered manager on 23 September 2019. CQC should have been notified within five working days from the first day of the registered manager`s absence.

The provider was in breach of regulation 14 of The Care Quality Commission (Registration) Regulations 2009. The information the provider sent to CQC was not made in a timely way and was not accurate.

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
● The provider had not been open and transparent with people or their relatives following untoward incidents or when safeguarding concerns were raised. For example, we saw records of incidents between people living at the home. Whilst these recorded that relatives were notified the Duty of Candour had not been followed.
● Duty of candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. There was no evidence in people's care records, discussions with staff or management to demonstrate where this had occurred.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Working in partnership with others
● There were few instances where the service worked in partnership with others. There were yearly reviews with day centres that some people attended.
● The provider was a member of a care provider association which provided some training for staff.
● The provider and registered manager had not developed links with any other organisations to develop their knowledge of good practice for services for people with learning disabilities.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of reportable incidents.

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 ensure people received care and support in a personalised way, accessed the community and had support to participate in meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people received care and support in a way to promote their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not able to demonstrate that they always followed the MCA principles and acted in people`s best interest where they lacked capacity to consent to the care they received.

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 Safeguarding systems and processes were not used effectively to protect people from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure that the environment was properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not been open and transparent with people or their relatives following untoward incidents or when safeguarding concerns were raised. The provider failed to inform people about the incident, provide reasonable support, provide truthful information and an apology.

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 14 Registration Regulations 2009 Notifications – notices of absence The information the provider sent to CQC was not made in a timely way and was not accurate.

The enforcement action we took:

Notice of Decision to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people`s well-being were not sufficiently mitigated to protected them from harm.

The enforcement action we took:

Notice of Decision to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and good quality care for people.

The enforcement action we took:

Notice of Decision to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough suitably qualified and skilled staff employed to meet people`s needs.

The enforcement action we took:

Notice of proposal to remove the location.