Mrs Mobina Ali

The Rose

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

The inspection took place on 15 November 2017 and was unannounced. At our last inspection on 6 February 2015, the service was found to be meeting the required standards in the areas we looked at. The Rose is a residential care home for up to three people with learning difficulties. At the time of our inspection three people were living at the home. Shortly after the inspection visit the funding authorities supported people to find alternative places to live due to concerns about the service.

The care service has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities using the service were not supported to live as ordinary a life as any citizen.

The provider and the registered manager are the same person. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The provider had not been present at the service since 03 September 2017 and they had not ensured the appropriate support was in place for people who lived at The Rose in their absence. At the time of our visit there was an acting manager in post who was not registered with CQC and who was covering the absence of the provider. The acting manager told us that they did not know when the provider would return.

People's health needs were not managed appropriately to ensure people were safe. Staff had not reported safeguarding concerns to help keep people safe.

Safe and effective recruitment practices were not followed to ensure that all staff were suitably qualified and experienced. There were no arrangements in place by the provider to ensure there were sufficient numbers of suitable staff available at all times to meet people's individual needs.

People who lived at The Rose had no best interest or mental capacity assessments (MCA) in place and staff did not promote daily choices for everyone.

Staff had not received inductions, training or competency assessments. People were not supported to express their views; they were not always involved with decisions about their care. Risk assessments did not address all areas of concern and lacked the guidance needed to inform staff how to keep people safe.

People were not supported to maintain their interests or develop personal goals.

There were no systems in place to monitor the quality and audit the service. Daily notes and other documentation such as reviews of care plans had not been completed since October 2016. Meetings for people and staff were not completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not kept safe by staff trained to recognise and respond to the risks of abuse.

Safe and effective recruitment practices were not followed to ensure that all staff were fit, able and qualified to do their jobs.

There were not sufficient numbers of staff available to meet people's individual needs at all times.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not have their capacity assessed and best interest decisions were not completed to promote people's choice.

People's wishes and consent were not obtained by staff.

People were not supported by staff that had received an induction and training to ensure they could meet people's needs effectively.

People were provided with a healthy balanced diet, which met their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always involved in the planning, delivery and reviews of the care and support provided.

The provider had not insured people's support and care needs were being met during their absence.

Staff were observed and able to demonstrate they promoted people's dignity and respected their privacy.

People's confidentiality of personal information had been

maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their needs or took account of their preferences and personal circumstances.

Care plans lacked guidance in certain areas to enable staff to provide appropriate care.

People were not supported to maintain social interests and take part in meaningful activities relevant to their needs.

People were not supported to talk about concerns or share ideas.

Is the service well-led?

Inadequate

The service was not well led.

Systems were not in place to quality assure the services provided, manage risks and drive improvement.

The provider had not ensured a proper hand over for the manager to ensure they knew what was required. The manager and staff did not feel supported by the provider.

The provider had not ensured people received appropriate support and care.

The manager had found lots of concerns and issues that required attention.

The Rose

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 15 and 17 November 2017 by one Inspector and was unannounced. The inspection was in response to concerns raised by a family member. We reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events that the provider is required to send us.

During the inspection, we spoke with three people who lived at the home, two relatives, two staff members and the manager. We also reviewed the commissioner's report of their most recent inspection. We looked at care plans relating to three people and three staff files and a range of other relevant documents relating to how the service operated.

Requires Improvement

Is the service safe?

Our findings

Where potential risks to people's health, well-being or safety had been identified, these were not assessed and reviewed to ensure the person was supported to receive any treatment or support to maintain their health needs. We were made aware of a health issue for one person that had been reported as a concern in April 2017. These concerns were serious but no action had been taken by the provider to ensure the person received the appropriate medical attention. The acting manager identified this concern when they commenced work at the service in September 2017. We found other examples where people required medical intervention which had only been sought after the acting manager intervened. Medical advice has now been sought and other professionals involved where needed.

Due to the provider disregarding the needs of the people for care or treatment. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

Recruitment practices were not safe and did not meet the regulations to ensure that all staff were of good character, physically and mentally fit for the roles they performed. For example, one person who previously had worked at The Rose in 2014 and had been reemployed again September 2017 but had no up to date reference check and the application on their record was from 2014. There was no evidence that a proper employment check had been completed at the point when they were reemployed. The three new staff members had not had a comprehensive induction. The acting manager told us that the induction had only been orientation of the home and to read the care plans.

The provider did not have effective processes in place to ensure that staff were of good character and have the qualifications, competence, skills and experience, which are necessary for the work.This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) 2014.

The acting manager explained that they needed to employ staff as a priority when they commenced working in the home September 2017 as there had been insufficient staff employed to provide care for people. The acting manager told us that the provider had not informed her of the staffing levels needed to ensure people's needs were met. The provider had not given an appropriate hand over and did not ensure the appropriate measures in place to meet people's needs. The acting manager told us that the provider had stated that they would cover some shifts on the rota themselves but had then failed to attend these shifts. The acting manager told us that they are working many more hours than they were contacted for to ensure the people who lived in the home received effective care and support. Following our inspection visit and prior to people moving out of The Rose, the local authority had had to provide additional staff to support people and ensure that their care needs were being met.

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014.

There was information and guidance displayed about how to recognise the signs of potential abuse and

report concerns, together with relevant contact numbers. Information was also made available in an 'easy read' format that used appropriate words and pictures to help support people with their understanding. One staff member told us, "If I had any concerns I would report them to the manager." They were able to demonstrate they could recognise concerns and escalate these concerns if required. They were aware of other organisations such as the local authority and the Care Quality Commission (CQC). However, although the acting manager and the staff were aware of how to raise concerns, they had not raised concerns about in relation to people's health needs being disregarded.

The home looked clean and tidy. The acting manager was starting to address areas of concern. For example, they had just recently had the carpet professionally cleaned in one person's room. They told us that they might be affected by dust and wanted to ensure the carpet was completely clean.

At the time of the inspection, we were told that there was no medicine regularly prescribed for people who lived at The Rose. One person was on antibiotics and the acting manager was managing this safely.

Plans and guidance were available to help staff deal with unforeseen events and emergencies which. For example, the fire alarm systems had just been inspected and the acting manager had updated the emergency evacuation plans to ensure people were safe in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and found they were not. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The acting manager was unable to demonstrate that people who lived at The Rose had received best interest meetings or mental capacity assessments (MCA). The acting manager had recognised this and had asked one staff member to complete these. However, the staff member did not have the training and did not fully understand how to assess a person's capacity. The acting manager confirmed that they were also not sure how assessments of people's mental capacity were undertaken. The acting manager told us that people were not free to leave the home due to safety concerns however, they were not aware of whether any authorisations were in place for people to be deprived of their liberty.

Therefore, there was a risk that people were being unlawfully deprived of their liberty. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) 2014.

People were supported to eat healthy meals and had their likes and dislikes noted in their support plans. However, people were not supported to have daily choices. For example, people were asked what they wanted to eat for their dinner. We noted not everyone who lived at the home were able to communicate verbally. One staff member said, "We ask [name of person who used the service who is able to communicate] what they want for dinner." they went on to explain that they served that person's choice to all of the three people living at The Rose. This meant that staff did not always offer people choices or support people with making decisions about the food they wanted. Staff did not take the time to ensure that each person had a choice and were involved in their day-to-day decisions.

We noted that there were pictures of different types of food that could be used to help support people to make decisions. However, these were limited. The acting manager had recognised this and told us they were updating the pictures. Although staff we spoke with understood the importance of choice, this had not always been promoted.

Staff had not completed an induction programme, or received training relevant to their roles, and had not had competency checks to ensure that they had the necessary skills and knowledge to provide support to people. The acting manager confirmed staff had received training from their previous jobs however, they did not have the certificates or further details to confirm this and had not checked the content of the training or that staff were competent in their roles.

The provider had not ensured enough suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and needs. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) regulations 2014.

People had not received care, treatment and support that promoted their health and welfare. People had not always received support from staff to access health professional when they needed to. For example, concerns had been raised by staff from a day service used by one person about their health. No action had been taken by the provider to support the person to seek medical advice or treatment in relation to these concerns until the acting manager came into post several months later.

Requires Improvement

Is the service caring?

Our findings

The provider had not ensured that people were provided with kindness, respect and compassion. They had not provided support to people that enabled them to express their views and be actively involved in making day-to-day decisions. For example, there had been no meetings for people using the service or documented evidence of people's views been sought. The provider had been absent from the service without ensuring that there were staff available to provide appropriate support for people to ensure their health and welfare.

Some people who lived at The Rose were not able to communicate verbally. One person we asked indicated by giving the thumbs up sign to verify they were happy living at The Rose. Another person said, "The staff are nice."

Staff were able to tell us how they promoted people's dignity and respect. One staff member described how they delivered personal care and they demonstrated they thought about the person's dignity and described how they promoted this, with the use of towels to cover the person, closing curtains and communication about what they were doing. They said, "I always communicate what I am doing and encourage them to do what they can."

The acting manager had previously worked at The Rose and had left in 2014. They told me when they returned that people living in the home were happy to see them. One person told us they liked the acting manager and they were nice. We noted the acting manager had a good relationship with people. The acting manager was able to tell us about people's needs and clearly knew them well. The atmosphere was homely. People at the home, had lived together since 2010 and were clearly comfortable living together.

Staff we spoke with understood the importance of confidentiality and people's records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

The acting manager told us that they had to update all of the care plans when they commenced employment at the service in September 2014 as they did not reflect people's needs. They told us that although the care plans stated they had been reviewed, they had not been updated since they worked there in 2014. They explained how one person's needs had changed and that but their care plans did not reflect this.

The acting manager had updated the care plans at the time of the inspection, they were personalised and captured the individual details for example, people's likes and dislikes. However, the care plan did not reflect all areas of their required support. For example, one person had been taken to the GP due to concerns. The GP has made a referral to investigate further, but there were no risk assessment in the care plan or guidance to staff on how their health concern should be managed. Risk assessments although updated were generic and did not address all concerns, this was also true of the support plans. For example, the support plan for one person around food had not addressed the risks that the manager was aware of and had not provided guidance for staff about how to safely support the person with eating and drinking. This meant that staff that provided support may not be aware of the risks. The manager was making many positive changes to ensure people were provided with better care.

Therefore, due to the provider not ensuring risk assessments addressed all areas of risk. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

People were not supported to maintain their interests and to take part in activities that they enjoyed. For example, we looked at the minutes for a residents meeting in September 2016. It was documented that one resident had asked that they could go to London to see the Christmas lights being switched on. They were told it is early but yes, they could go to London. We spoke with the person who confirmed they had not been supported to see the lights turned on for Christmas. We also noted there had been no meetings held for people at The Rose since October 2016. The acting manager explained that she was introducing monthly meetings for people to be able to voice their concerns and ideas.

People who lived at The Rose all attended day clubs each weekday. At weekends the acting manager said if people want to go out for a walk this could happen but people did not really want to do much as they had had a busy week. However, people were not supported to develop new skills, pursue hobbies and interests or encouraged to grow or gain independence. There were not enough staff to give the flexibility for an individual to go out on their own meaning that if people wanted to go out this had to be as a group. Rotas we looked at demonstrated that there was only one staff member on duty at the weekend from 08:00 until 15:00. This meant that if one person wanted to go out then everyone would have to go.

The provider did not ensure people received personalised care that met their preferences and was specific to them. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw that information and guidance about how to make a complaint was displayed in an 'easy read' format appropriate to people who lived at The Rose. However, there were no complaints recorded. The acting manager was unable to confirm whether people had made complaints or raised concerns. There was no evidence to show us the provider had actively sought people's views to ensure they were happy with all aspects of the service.

The provider did not to ensure there were effective systems for identifying and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

The registered manager who is also the provider has not been present at the home since September 2017. The acting manager told us that they did not know when the provider was planning to return. The acting manager explained that the provider had requested to be placed on the rota for September but they had not attended any of their shifts. The acting manager had not seen the provider and told us they believed the provider was out of the country. One relative told us, "The [provider] is coming back in January" but we were unable to confirm this with either the acting manager or the provider. The acting manager told us that on arrival at the home the only update the provider had given them was actions required from a recent local authority inspection. Following our inspection the funding authority provided staff to ensure people were safe and people were then supported to move to other homes where their support needs could be met.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had not informed the CQC of their absence from the service.

The provider did not inform CQC about any planned or unplanned absences that are for a continuous period of 28 days or more, how the service will be run while they are away and when they will return. This was a breach of Regulation 14 of the Care Quality Commission (registration) Regulation 2009.

We found that there have been no audits completed since October 2016 and there were no action or improvement plans in place. There had been no reviews of care plans or documented daily notes. The provider had not actioned concerns raised about people's health. Staff meetings and service user meetings had stopped in October 2016. There were no supervisions or support in place for staff. Training and inductions for new staff were not in place.

The provider had not ensured people received appropriate support and care. The acting manager who started in September told us that on their arrival at the service in September 2017 they had to replace the front door because this was broken and could not be secured properly, they explained "I couldn't leave it like that, it wasn't safe."; they also told us that they found the garden areas both front and back overgrown. The acting manager told us staff wages had not been paid by the provider.

The acting manager confirmed the provider had not supported them, had not provided a handover and told us that there had been little communication from the provider since the acting manager commenced employment in September 2017. This meant the provider had not ensured that arrangements were in place to support and care for people using the service and had not overseen the service since they left on the 3 September 2017. The acting manager explained that since taking up post they had prioritised a list of actions that were required and told us their main priority was to employ staff and to ensure people's needs were being met.

We found that there were no systems or processes for monitoring the quality of the service. We identified concerns in relation to staffing; recruitment and training; risk management of people's individual risks and

the environment; safeguarding people from abuse and neglect deprivation of liberty and choices; access to personalised hobbies and interest; effective governance and monitoring systems.

The provider was not providing safe, effective or appropriate care for people living at the service. Therefore, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2017.

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 14 Registration Regulations 2009 Notifications – notices of absence The provider did not inform CQC about any planned or unplanned absences that are for a continuous period of 28 days or more, how the service will be run while they are away and when they will return.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people received personalised care that met their preferences and was specific to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent the provider did not ensure people were supported to make choices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure risk assessments addressed all areas of risk and were reviewed regularly.

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 disregarded the needs of the service user for care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not to ensure there were effective systems for identifying and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to monitor the service against regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have effective processes in place to ensure that staff were of good character and have the qualifications, competence, skills and experience which are necessary for the work.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured enough suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and needs.