High Street Lodge Limited

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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

This inspection took place on 5 and 7 December 2018 and was announced.

High Street Lodge Ltd provides care and support to people living in three 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone using High Street Lodge Ltd receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service supports people with a mental health condition. The service can accommodate a maximum of 17 people. On the day of the inspection there were nine people using the service.

A registered manager was in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

High Street Lodge has been inspected three times since February 2016. In February 2016 we found significant shortfalls in the care people received and the way in which the service was managed. We identified breaches of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to inadequate risk assessments, people not being involved in planning their care, inadequate provision of staff training, staff not understanding of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), a lack of staff supervision and a lack of auditing processes to ensure good governance and overall management of the service. Enforcement action was taken against the provider and the registered manager.

In September 2016 we inspected the service to check whether the required improvements had been made. We found that although some improvements had been made the service continued to be in breach of the regulations. We found that some aspects of risk management were not safe and there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the serious nature of the breach we took further enforcement action against the registered provider.

In April 2017 we carried out a focused inspection to check that the most significant breach of legal requirements in relation to Regulation 12, concerning risk assessments, which had resulted in enforcement action, had been addressed. During this inspection we found that the provider had addressed this issue and were no longer in breach of the regulations. The service was rated overall 'Good'.

At this inspection we found significant concerns and shortfalls in the care and support people received and the overall management of the service. Improvements that had been made previously had not been sustained.

Although the service identified and assessed people's risks associated with their health and care needs, not all risks were appropriately assessed. This meant that care staff were not given appropriate information and guidance on how to manage people's risks and keep them safe and free from harm.

Medicines management and administration was not safe. People were not always receiving their medicines safely and as prescribed.

Senior care staff completed monthly medicines audits, however, these did not identify any of the issues that we highlighted as part of this inspection. The registered manager did not monitor and evaluate the overall quality of care and support people received so that issues could be identified, improvements made and further learning and development implemented.

The registered manager and senior care worker had not improved on their level of knowledge on how to meet the regulations, especially considering that the service had a history of non-compliance.

People did not receive care and support that was in line with current best practice and reflective of their needs and requirements. Where change in people's health and care needs had occurred, care plans had not been reviewed or updated to reflect this.

Records written about people, especially in relation to incidents, were not person centred. People were not referred to with dignity and respect.

Although we observed sufficient numbers of staff available to meet people's needs we could not always be assured that where people required support to go out and take part in activities, sufficient number of staff would be available to support them.

People were not supported to engage and participate in a variety of activities that they may have enjoyed. People were observed sitting at home either in the lounge or in their own bedrooms with very little in the form of stimulation available to them to support them with positive well-being.

The service had not involved people or their relatives to give feedback about the quality of care and support that they and their relative received. This meant that the service was unable to learn and improve where required.

Care staff told us and records confirmed that they were supported through regular training, supervision and annual appraisals. However, where care staff received medicines training, competency assessments were not completed to assess that staff were competent when administering medicines.

People and their relatives told us that they felt safe when receiving support from the care staff at High Street Lodge Ltd. Care staff demonstrated a good understanding of how to recognise abuse and the steps they would take to report this.

Safe recruitment processes in place ensured only those staff assessed as suitable to work with vulnerable adults were employed.

People told us that they had enough to eat and drink. Some people were able to purchase and cook their own food and staff supported them. In some houses, staff cooked for people. Care staff told us that people were given choice when deciding what to eat.

People were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People, where possible, had consented to the care and support that they received.

The service had no recorded complaints since the last inspection. Policies in place gave clear direction on how people and their relatives could complain. People and their relatives knew who to speak with if they wanted to raise a concern.

We identified breaches of Regulations 9, 10, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks associated with certain health conditions and support needs had not been assessed to give guidance to support staff on how to minimise those risks and keep people safe from harm.

People did not receive their medicines safely and as prescribed.

People's personal emergency evacuation plans were not available to guide staff and emergency services on how to safely evacuate people in case of an emergency. Fire safety checks and drills had not been recorded.

Safe recruitment processes were in place. However, sufficient numbers of staff were not always available to support people.

Accidents and incidents were recorded and reviewed so that learning and improvements could be identified to prevent future recurrences.

Is the service effective?

Requires Improvement

The service was not always effective. Although staff received regular training and support, staff competency in medicine administration had not been assessed.

People were seen to be supported with their nutrition and hydration needs where required, however, feedback from relatives was not positive.

People's needs were assessed so that the service could confirm that their needs could be effectively met before a placement was offered.

Support staff understood the key principles of the Mental Capacity Act 2005 and how these were to be applied when supporting people.

People were supported to access a variety of health care professionals where required.

Is the service caring?

Requires Improvement

The service was not always caring. The language used in written records was not always respectful of the person involved.

People and their relatives were not involved in the day to day planning and decision-making process of the care and support that they received.

Support staff knew how to support people in ways which respected their privacy and dignity.

People were supported to promote their independence where possible. Support staff gave examples of how they achieved this.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not current. Some care plans had not been reviewed and were not reflective of the person's needs and requirements.

People were not supported to participate in meaningful activities which promoted positive well-being. Support staff initiated very little interaction and stimulation.

People were not supported to achieve goals and tasks that they had identified to promote their skills and abilities.

People and their relatives knew who to speak with if they had any complaints to raise.

Is the service well-led?

Inadequate

The service was not well-led. The registered manager had insufficient oversight of the quality of care and support that people received.

The service had not sustained any of the improvements that they had made since the last inspection and following previous enforcement action that had been taken in 2016.

The registered manager had no awareness of the issues we found as part of this inspection. Medicine management audits completed monthly failed to identify the issues we found.

Systems were not in place for the service to consider people's experiences and identify issues so that learning and improvements could be implemented.

People and their relatives knew the registered manager and were complimentary about them.

Support staff were supported through a variety of processes which included staff meetings. Staff felt able to make suggestions and share experiences.	

High Street Lodge Limited

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 5 and 7 December 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available to support us with the inspection process.

This inspection was carried out by one inspector and one expert by experience. During the inspection we visited the office and two of the supported living schemes. The expert by experience made telephone calls and spoke with the relatives of people using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We also reviewed information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and well-being of people using the service.
We spoke with three people who used the service and five of their relatives. We also observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

We spoke with the registered manager, senior support worker and three support staff. We also looked at four staff files and training records.

We looked at five people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including staff meeting minutes as well as health and safety documents, complaints and quality audits.

Inadequate

Is the service safe?

Our findings

People and their relatives told us that they felt safe with the care and support that they and their relative received from support staff at High Street Lodge Ltd. One person told us, "I feel safe here." Relatives comments included, "I think she is safe, yes" and "Yes, she is safe." However, despite the positive feedback we received, there were aspects of the care and support that people received which were not safe.

Each person, as part of their care plan, had risk assessments in place which identified and assessed risks associated with their health and care needs. This included risks associated with behaviours that challenged the service, mobility, nutrition, obesity, self-neglect, verbal aggression and anxiety. Risk assessments detailed the risk factor, triggers or reasons for the risk and an agreed action plan for support staff to follow to minimise the known risk.

However, we found that where people had identified health conditions such as diabetes, risk assessments were not in place which gave guidance to staff on how to support the people with the condition and to minimise any known risks. For example, where people were at risk of having a hypoglycaemic or hyperglycaemic episode, there was no information available for support staff on how to manage these conditions and support the person accordingly. Hypoglycaemic or hyperglycaemic episodes are when a person's blood sugar levels suddenly drop or are at a high level which have a significant impact on their health.

For another person, who was undergoing treatment for an identified health condition, risk assessments were not in place highlighting the risks associated with the condition and the treatment and how the person should be supported to manage these safely.

Where people were at an identified risk of leaving the service without informing staff of their whereabouts, care plans had not been updated to highlight the risk, especially following a specific incident. Care staff had not been provided with a risk assessment telling them how to support the person so that the risk of them leaving and to ensure their safety could be managed. This meant that people were placed at risk of receiving care and support that would not enable the person to remain safe.

Medicines administration and management was not safe. Care plans documented people's medicines support needs and listed the medicines that they had been prescribed. However, where people had been prescribed medicines to be taken 'as and when required' (PRN), a PRN protocol had not been created giving information and direction to support staff on how and when these medicines should be administered. This includes medicines that help people when they become anxious or are in pain.

People had been prescribed specific medicines that were not appropriate to be in a blister pack and these were clearly labelled with the person's name and kept in the medicines cabinet. A blister pack system provides people's medicines in a prepacked plastic pod for each time medicines are required. However, the service did not keep a record of stock levels of those medicines. Therefore, the service was unable to confirm that the number of remaining tablets was correct.

One person had been prescribed two different types of pain relief. One had been prescribed to be administered 'as and when required' and the other had been prescribed to be administered four times daily. On Medicine Administration Records (MARs) dated 25 October 2018 to 21 November 2018 and 22 November 2018 to 19 December 2018 we saw that the person was receiving both medicines consistently from the 25 October 2018 till the 30 November 2018 and 24 November 2018 respectively. Following these dates support staff had recorded on the MAR that the person had not been administered these medicines. We highlighted this to the registered manager and the senior support staff who were unable to give a definitive explanation as to why the person's pain relief had been stopped. We were told that the pharmacy had not sent any stock and that they had assumed that the GP had stopped prescribing the medicine. There was no evidence of a recent review having been conducted by the GP. Therefore, the person had not been receiving any form of pain relief and may have been in significant pain.

On the second day of the inspection we asked the registered manager and the senior support staff whether they had reviewed this with the GP. We were told that an appointment had been arranged with the GP for four days after the issue had been highlighted to the service but no immediate explanation had been sought and immediate alternative pain relief had not been arranged.

For the same person, who was receiving treatment for a health condition, they had been prescribed a specific medicine which needed to be administered before they received the treatment and for one day after receiving the treatment. However, there was no current MAR in place confirming the person had received this medicine. The last record of the person receiving this medicine was on 15 November 2018. This meant that this person may not have been receiving their medicines safely and as prescribed.

The same person also had a medicine prescribed that had to be administered on specific days of the week. We saw gaps in recording where the person had not received this medicine as prescribed on 5 October 2018 and 30 November 2018. There was no explanation available as to why this person had not received this medicine and when we asked the registered manager and senior support staff they were unable to give any further explanation. This meant that the person was at risk of not receiving their medicines as prescribed.

For another person who suffered with migraines, the care plan stated that the person was taking Sumitriptan. However, when we looked at the person's MAR there was no record of this medicine being administered. There was no stock available in the medicines cupboard. We brought this to the attention of the registered manager who informed us that the medicine was a 'homely remedy' which the service did not manage and that the person carried it with them and self-administered. We could not confirm this, however, the care plan stated that the person required full support with the administration of their medicines. Although this medicine was available to purchase at a pharmacy, this was a medicine which required scrutiny and checks to ensure that person who required this would be able to take it safely. There was no record of this in the person's care plan. This meant that the service were unaware of any risks or side effects associated with this medicine and whether the person was self-administering this medicine safely.

On the second day of the inspection we observed the senior support staff administering medicines for one person. We saw that all medicines were dispensed from the blister pack and medicine packaging without referring to the person's MAR. This was not good practice and put the person at risk of receiving the wrong medicines.

All staff had received medicines administration and management training which was refreshed on an annual basis. However, there were no records confirming that staff competency in administering medicines safely had been assessed. Support staff told us that competency had only been assessed during their induction and had not been assessed again since then. Medicines audits were completed on a monthly basis by the

senior support staff, however, these had not identified any of the issues we had found during this inspection.

We asked the senior support staff about the checks that they completed to ensure people were kept safe from the risk of a fire at the scheme. We were told that regular checks of the fire alarm as well as regular fire drills were completed. We asked to see records of these, however, we were told that these were not available at the office and that they were held at other schemes. Records of these checks were not made available to us during the inspection. Therefore, we were unable to confirm that these checks did actually take place to ensure people's safety. People's care plans did not contain personal emergency evacuation plans explaining the support that they may require to evacuate the property in an emergency.

All of the above was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection we observed sufficient numbers of staff available to support people with their care needs. However, we were told by some support staff that people were not always able to go out or participate in activities outside of the scheme due to there not being sufficient staff available to accompany people. On both days of the inspection we observed at one scheme where there were four people living, only one support staff was available. Rotas seen from the 27 November 2018 till the 9 December 2018 also only evidenced that on certain days there were only one staff member available during the day especially at one particular scheme where four people resided. This meant that the staff member had to stay in the scheme so was unable to support anyone to go out.

The service did not undertake any needs assessments to ascertain the numbers of staff required to safely support people. The service made informal judgements and allocated staff accordingly based on observation.

The registered manager and all staff that we spoke with understood the term 'safeguarding', were able to describe the signs they would look for if they suspected abuse and how this was to be reported. Safeguarding policies in place supported the service to identify and report concerns, with processes in place to investigate concerns and implement the required improvements where necessary. Support staff knew of the term 'whistleblowing' and the agencies such as the local authority and CQC that they would contact to raise any concerns.

The service followed appropriate recruitment processes to ensure that only those staff assessed as safe to work with vulnerable adults were employed. Checks had been completed by the Disclosure and Barring Service. These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held documentary evidence confirming proof of identity, an application, employment history and references confirming the staff member's conduct in previous employments.

However, where potential care staff had completed application forms and were required to provide a full employment history, this had not always been provided and the registered manager had not always explored any gaps in employment. This meant that the service may be at risk of employing staff without fully exploring their previous employment history and conduct in past employment.

Accidents and incidents were recorded with details of the incident and the actions taken as a result. The registered manager and support staff told us that all accidents and incidents were reviewed and discussed with support staff immediately after the event so that further learning and improvements could be

implemented to prevent future recurrences. However, we did find that the written language used in completing these records was not person centred and was not respectful of the person involved in the incident. This has been reported on further under the key question 'Caring'.

All staff received infection control training and had access to a variety of personal protective equipment such as gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

Many of the people that were supported by the service were unable to communicate with us to give us feedback about the staff that supported them. We asked relatives whether they felt support staff were appropriately trained and skilled to carry out their role. One relative told us, "I'm generally happy with the staff, it is mixed who you go to for certain things." Another relative stated, "Staff skills; a lot of them have few skills it depends who is on duty. A third relative commented, "There is a mix. A few of them are good."

The service ensured that prior to a placement being agreed a needs assessment was completed so that the service could confirm that they were able to meet the needs of the person effectively.
The service then developed a care plan which gave detail and guidance to care staff on the person's needs, their risks and how the person wished to be supported. Care plans including risk assessments were reviewed every six months or sooner. However, we found two care plans that had not been reviewed since 2017. This has been reported on further under the key question 'Responsive'.

Support staff told us, and records confirmed, that they had received an induction and regular training which enabled them to carry out their role. Records showed that all staff had received training in the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), safeguarding, food hygiene, first aid, managing behaviours that challenge, medicine administration, fire safety, infection control and moving and handling. However, there were no records confirming that staff competency had been assessed especially when administering medicines. Support staff told us that competency had only been assessed during their induction and had not been assessed again since then. A newly employed member of support staff confirmed that they had undergone an induction before they started working with people. They said, "I had an induction for a week, I was partnered up with someone. I had someone with me for about 12 weeks so that I could get used to everyone."

Support staff told us that they regularly received supervisions and an annual appraisal which allowed them to discuss their work practices, training needs and future development. Support staff were positive about the support that they received and told us, "We talk about what is my day, how I support clients" and "[Registered manager] does our supervision on a monthly basis. Normally we talk about the patients, how they have been cared for, what we can do to help. It is helpful, it gives us a chance to give feedback, maybe suggest improvement."

People were supported with their nutrition and hydration needs where required. Some people were able to make their own choices, go shopping for their food items and were able to cook their own meals with minimal support. Some people, however, required full support with their meal preparation. We were told by the registered manager and support staff that people were always given a choice as to what they wanted to eat and drink and were supported to devise weekly shopping lists which incorporated their choices. We saw people had access to a variety of snacks and drinks throughout the day. On person told us, "Food is alright. I am able to choose what I want but they don't have what I want so if I want fish and chips there is nowhere here to get it." Another person said, "I go out and I decide what I want to eat and [support staff] helps me."

However, relatives' feedback about the support people received with their meals was not positive. Feedback included, "Food is an issue, there is a definite lack of proper food and he is diabetic" and "They have no menu and he seems to live on ready meals, oven chips with everything including burgers and fish fingers. He loves Caribbean food, rice chicken and they say they prepare food but I don't think they do there just seems to be no planning."
We recommend that people's dietary likes and dislikes are clearly noted and a menu is compiled for each person which is reflective of their choices but also promotes healthy eating.

Records within care plans confirmed that the service worked effectively together and with other health care professionals to ensure people received the appropriate care and support to effectively meet their needs. Daily records gave a day to day account of the person, how they were, any significant events and any outcomes to be actioned as a result of appointments, visits or activities that the person had attended. Records included the involvement of GPs, community psychiatric nurses, social workers and district nurses.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. The registered manager confirmed that people supported by High Street Lodge Ltd at the time of the inspection did not require a 'judicial DoLS'.

Care plans had been signed by people consenting to the care and support that they received. Most people had the capacity to make their own decisions and we saw that care plans clearly reflected this. However, for one person, following a hospital appointment a request had been made to the service to make a referral to the person's GP for a capacity assessment. The request had been recorded on 29 November 2018. We asked the registered manager whether the referral had been requested and we were told that due to the GP not being available at that time the referral had not been submitted.

Support staff that we spoke with understood the key principles of the MCA and how these principles were followed when supporting people with their care and support needs. Feedback from support staff included, "We just have to be patient, it's a step by step thing. I'd give them the benefit of the doubt and I would ask them, I'd give them choice but on the other hand have to be mindful of their mental state" and "Normally they have their next of kin and we can ask them what the client wants and doesn't want. When I am cooking I will ask them what they want their rights and choices, it's part of their rights to be asked even if they couldn't make a decision."

Requires Improvement

Is the service caring?

Our findings

One person told us, "Carers are alright. Carers come with me to the hospital. They do help me but not that caring." Another person told us, "Carers are lovely. I am really happy here."

However, our observations during the inspection did not show that the service was caring. Throughout both days of the inspection we saw very little interaction between people and support staff. There was very little conversation and people were seen to either spend most time in their bedrooms or sat in front of the television with nothing else to do. We observed one person talking to themselves and sometimes sobbing with no reassurance or sympathy offered by support staff. The only conversation that took place between people and support staff was when support staff asked people if they wanted a drink and when it was time for people to have their meal. We did not see any interaction that showed that people had support staff had established a positive and caring relationship with people using the service.

One relative told us about communications that they had experienced between people and support staff and said, "Their language skills are not great. I don't know whether it is a cultural thing. The staff are not rude but they use the wrong tone of voice which to some could be very upsetting."

We found that the manner in which incidents had been recorded including the way in which people were spoken to was not respectful or dignified. We saw two incident records and minutes from a meeting between the registered manager and a person following an incident. People were spoken to in a disrespectful manner. People were not supported in a positive way to express themselves and to raise concerns they had. Examples of this included, 'This type of behaviour is not accepted in High Street Lodge and is considered as serious offense by accusing a staff falsely. [Registered Manager] warned him [person] not to accuse staff falsely', '[Registered manager] came in to talk to [person]. [Registered manager] said sometimes when she comes in she notices that [person] shouts at the boys and talks to them any how so she should put a stop to that' and 'She [registered manager] again made it clear to [person] not to argue with staffs or shout at staffs but to respect both staffs and other clients. Also when staffs tell her something she should listen because they are words from her as manager.'

One relative also told us about one of the incidents referred to above which had led to support staff continuously saying to the relative, "They are never going to trust him again."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Support staff gave examples of how they ensured people's privacy and dignity was respected. One member of support staff told us, "You have to ask, knock on their doors, never forget to be patient especially when they make mistakes." Another member of support staff said, "Everybody is entitled to privacy and to keep their dignity. You don't discuss their issues in front of people, call them in the privacy of their rooms, don't call them derogatory names."

Care plans detailed people's likes and dislikes and the ways in which they wished to be supported. We saw that for day to day tasks and activities people were involved in making these decisions. Care plans also evidence people's involvement in the planning of their care. For one person who disagreed with some of the risk areas identified by the service, the person had written down comments next to those areas of their care plan that they disagreed with. Relatives confirmed that they were involved in the care planning process and were kept informed about the person and any significant events. One relative told us, "Yes I am involved, they have a meeting every so often that I'm included in."

We saw people's independence being promoted where possible. We observed people making their own drinks and meals with support only being offered by staff where required. People were able to go out independently when they wished, with some people having their own keys to their home. Support staff understood the importance of promoting people's independence and told us, "They [people] have the key to their home, they can come in and out as they please, we check up on them, where they are going. Those who manage to cook we support them. Food is in the fridge. They take what they want, we are just their supporting them" and "I guess it's more about communication. I ask and see and support their independence."

Requires Improvement

Is the service responsive?

Our findings

Care plans were person centred and listed people's likes, dislikes and choices along with information about how they wanted their care and support needs to be met. However, care plans were not always current and reflective of people's needs, especially where change had been noted in how the person was to be supported.

One person's care plan had recorded that they were required to wear a body brace whenever they were upright to support their back. During the inspection we saw that the person was not wearing the brace. When we asked the registered manager about this, they told us that the GP had told the person that they no longer needed to wear the brace. This important change had not been updated within the care plan. For the same person their care plan also recorded that they had a mental health condition. However, there was no further information on how their mental health affected them, their behaviour and their daily living activities.

One person recently, whilst attending an appointment, had left the hospital without informing the support staff member who was accompanying them of where they were going and when they would return. The person did return safely to the scheme the next day, however, this significant incident had not been updated in the person's care plan, with the required risk assessments so that staff would know the steps to take to minimise the risk of reoccurrence. The lack of updated information and review of this person's care and support needs meant that the person may not have been supported in a safe and appropriate way which was responsive to their needs.

The registered manager told us that care plans and risk assessments were reviewed on a six monthly basis or sooner where change had been noted. However, in addition to the care plan we have referred to above, a further two care plans had not been reviewed since 2017, although the risk assessments for those care plans had been reviewed every six months.

Care plans noted that each person had an allocated key worker. Key workers are staff that support people to review their care needs, think about goals they want to achieve and help the person manage any other additional needs and requirements they may have. However, records seen of key worker meetings with people did not evidence meaningful or productive conversations which reviewed their care and support needs, addressed goals, activities or future aspirations. Questions that key workers asked people included, 'How are you?' 'Did you sleep well?', 'What would you like to eat tonight?' and 'Would you like to go shopping?'

Key workers were scheduled to hold meetings, with the people they were allocated to, on a monthly basis. However, care plans that we looked at did not evidence this. For one care plan there were no key worker meeting minutes available suggesting that none had taken place. For another person the last recorded key worker meeting was held in June 2018. Therefore, people were not encouraged or supported to engage in any meaningful conversation which enabled them to think about their goals and things they may want to achieve in their lives.

During the inspection we observed people were involved or engaged in very little activity or meaningful stimulation. People were seen to be either in their bedrooms or sat in the communal areas with very little to do, with the television switched on in the background. Where people were able to go out independently, we saw them leave the scheme as and when they so wished.

On the first day of the inspection we saw one person sat in the communal lounge with nothing to do. The television was on in the background. We could not confirm whether the person had been asked what they wanted to watch. The senior support worker was sat with the person, but was not engaging with them apart from when they asked the person if they wanted a drink or if they wanted to go for a walk. The senior support staff continued to sit next to the person and was reading a book. When we told the registered manager and the senior support staff of our observations, the senior support staff responded by telling us that he was reading to the person. However, this was not the case.

At another scheme we visited we observed two people sat in front of the television, dozing, at 5.15pm. There was minimal interaction between the support staff and people living at this scheme during our visit.

On the second day of the inspection we observed the same person who we had seen on the first day of the inspection, again sat in the lounge with the television switched on with very little interaction between them and support staff. Around 10am, the senior support staff supported the person to come into the office. The person was sat down at the desk whilst the senior support staff explained that the person used to work in an office. However, the senior support worker left the person sat at the desk and left the office. The person was not engaged in any form of activity or stimulation that may have been related to his working life which may have supported positive well-being.

Daily records did not record any form of engaging or stimulating activity other than watching television, listening to music, going for walks, knitting and colouring. For one person, their care plan had an activity plan which listed a variety of activities that the person would like to be involved in which included going for a bus ride, cycling, playing football and going to the coffee shop. However, daily records did not record any of these having taken place. Another person's care plan said that they wanted to learn how to use a computer and the internet. There was no evidence that the person had been supported to achieve this goal. There was no computer available at the scheme for the person to access. One relative told us, "He was meant to be doing a music activity about a month ago; that has not happened."

One support worker told us that people did not do a lot to occupy themselves. We were told that staffing levels did not allow staff members to organise activities and outings as there was only ever one staff member allocated to a scheme where there were four people requiring support. This meant that they were unable to leave the scheme to support people to participate in any activity or outing.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not received any complaints since the last inspection. We were shown a complaints policy which outlined the process they would follow to investigate and resolve any complaints that people and their relatives had. People and their relatives we spoke with knew who they would speak to if they had any concerns to raise and were assured that their concerns would be dealt with. One relative told us, "I have complained I have never gone as far as needing to make a written complaint." Another relative said, "It [complaint] was dealt with straight away and sorted out."

Inadequate

Is the service well-led?

Our findings

People and their relatives knew the registered manager and felt able to approach them regarding their care or the care of their relative. One person told us, "[Registered manager], I know she might be the boss." Relatives' feedback included, "[Registered manager] is very helpful if I have any problems I just ring her" and "[Name of registered manager] the manager is good." However, despite this positive feedback, we found that the service was not well-led.

The registered manager had not carried out any audits to check and oversee the quality of care people received. The only audit completed by the senior support staff was a monthly medicines audit. However, this did not identify any of the issues we found with the management and administration of medicines during this inspection. The registered manager had no systems in place which would have identified any of the other issues we found as part of this inspection. When we asked the registered manager about her oversight of the service she told us that although she did not complete any checks she was, "updated regularly."

Throughout the inspection we found that neither the registered manager or the senior support staff had any clear awareness of how they were to meet the regulations to ensure people received a safe, effective, caring and responsive service. Where we highlighted issues to the registered manager, responses we received included, "Thank you we will do this" and "I have learnt something today." This meant that people were placed at significant risk of harm and were at risk of not receiving care and support that was current and reflective of their needs and requirements.

After identifying the issues we had found on day one of the inspection, whilst giving feedback, the registered responded by saying, "I am going to get more staff" and "I need to shake up the establishment." On day two of the inspection, when giving the final feedback of the inspection process, we also asked the registered manager if they had taken any immediate steps to remedy the issues we had found. The response we received was, "We were waiting for you to finish." This meant that people continued to be at risk of, for example, unsafe medicines administration as the service had not taken the opportunity to address any of the issues to ensure people received their medicines safely and as prescribed. The service had not sustained any of the improvements that had been made as a result of past non-compliance and enforcement that had been taken by the CQC. One staff member told us, "Since [deputy manager] has gone it's my opinion things have gone down; he was very engaging."

Systems were not in place for the service to consider people's experiences and identify issues so that learning and improvements could be implemented. When we asked the registered manager whether they had asked people or their relatives to complete a satisfaction survey we were told, "Haven't done that for a long time. People and relatives come and tell us." We also asked the registered manager about residents or relatives meetings and were told, "We do relatives and resident meetings; sometimes." However, the registered manager was unable to locate any records of these. One week after the inspection we were sent records of three meetings that had taken place in the last year. We asked relatives whether they had been asked to give any feedback about the service. One relative told us, "I have never been to a relative's meeting or had a questionnaire."

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

Staff told us that they felt supported in their roles through various processes which included supervisions, annual appraisals and regular staff meetings. Minutes of meetings were not available during the inspection; however, we were sent a copy of the minutes of one staff meeting held in November 2018 one week after the inspection. Topics for discussion included service user concerns, cleaning and care plans. Support staff told us that they felt able to participate within meetings by giving their ideas and suggestions and sharing experiences.

The registered manager told us that they worked in partnership with a variety of healthcare professionals so that the service supported people to access the appropriate services. This included links with the community mental health team, psychiatric nurses, social workers and consultants.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving care and support that met their needs and reflected their preferences. Care plans were not current and reflective of people's care and support needs. Where change had been noted, care plans had not been updated to reflect the change. Poor provision of meaningful interaction, stimulation and activity meant that people were not supported to maintain positive well-being.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. Written references about people within incident reports and meeting minutes were not respectful and dignified.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Identified risks associated with people's health and care needs had not been assessed. The service had not done all that was practicably possible to mitigate suck known risks to keep people safe. Medicines management and administration was

not safe.

Documentation was not available to confirm that fire safety checks had been completed. People did not have personal emergency evacuation plans to ensure their evacuation from their home was done safely.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no systems and processes in place which enabled the service to assess, monitor and improve the quality and safety of the care and support people received. Medicine audits completed on a monthly basis failed to identify the issues that found as part of the inspection. The service did not seek and act on feedback from people, their relatives or any other involved stakeholders for the purposes of continually evaluating and improving the service they provided.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration.