Life Opportunities Trust

186-188 Lowdell Close

Inspection report

186-188 Lowdell Close
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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?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
186-188 Lowdell Close is a residential care home providing personal care to four adults with learning and physical disabilities. The service is managed by Life Opportunities Trust, a charitable organisation running care homes in London and the South East of England.

People's experience of using this service:
There were not enough staff deployed to meet people's needs or keep them safe. This meant that they did not always have varied or meaningful activities, their personal care needs were not always being met and their choices were not always considered. A high proportion of the staff supporting people were temporary staff sourced from agencies. Whilst the provider tried to source the same regular workers, this was not always the case, and many of the staff were unfamiliar with people's needs.

People's needs were recorded in care plans, but these needs were not always being met. People did not participate in social or leisure activities and did not access the community. Their personal care needs were not always being met. The staff showed limited understanding about meeting people's sensory needs or supporting people with their communication.

The outcomes for people using the service did not always reflect the principles and values of Registering the Right Support. People's care was not person-centred or proactive. The support from staff did not focus on promoting people's choice and control in how their needs were met.

The staff did not always have the skills or experience to provide effective care. They had received some training in order to provide safe care. However, they had not received support and information to help them understand about the different and more complex needs of people living at the service. They did not reflect on their practice to look at ways in which they could improve the care being provided.

Some of the time, staff did not show care or respect toward the people they were supporting. They did not always offer choices or take time to consider what the person was trying to communicate.

One of the hoists used for accessing a bath was broken and had been for over two months. This meant that three of the four people who lived at the service had not had access to a bath during this time.

The provider's systems for identifying, assessing and mitigating risks had not always been operated effectively. The provider and staff carried out audits of the service but these had failed to ensure that people were always safe and that their needs were being met.

Feedback from one person's relative was positive. They said that they felt the person was safe and well cared for.

There was a calm atmosphere at the service and the staff were gentle when they approached people and when supporting them. People looked at ease in the home and with the staff.

Some of the principles and values of Registering the Right Support were being followed. People were supported to access the healthcare services they required. There was evidence that the provider had sought guidance and support from different healthcare professionals to make sure they were providing care which met people's health needs.

People were given enough to eat and drink. Meals were freshly prepared at the service and the staff offered people choices.

The provider had acted in line with the requirements of the Mental Capacity Act 2005. They had made appropriate applications for the legal authorisation to deprive people's liberty for their own safety. They had also tried to explain different aspects of the service to people and gain their consent for specific care interventions. The provider had involved people's families and other representatives when making decisions about their care.

Rating at this inspection:
We have rated the service as requires improvement for all of the key questions. This was because the service was not always safe, effective, caring, responsive or well-led. The overall rating of the service is requires improvement.

We identified breaches of four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person centred care, premises and equipment, good governance and staffing. You can see what action we have asked the provider to take within our table of actions.

Rating at last inspection:
The last inspection of the service was 29 December 2016, when we rated the service Good.

Why we inspected:
The inspection was a scheduled/planned inspection based on the previous rating.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. We may inspect sooner if we receive any concerning information.

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 always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-led findings below.

186-188 Lowdell Close

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection visit was conducted by one inspector over one day.

Service and service type:
186-188 Lowdell Close 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:
The inspection was unannounced.

What we did:
Before the inspection we looked at all the information we held about the service. The registered manager had completed and returned a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We viewed information we had received about the service and notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also looked at publicly available information about the provider which included internet searches.

During the inspection, we met all four people who lived at the home, two support workers (one an employee

of the provider and the other a staff member sourced from an agency), and the registered manager. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at records used by the provider for managing the service. These included the care plans for all four people, staff training and support records, records of quality monitoring and audits, information about medicines and we inspected the environment.

After the inspection visit we spoke with the relative of one person who lived at the service.

We gave feedback about our initial findings to the registered manager.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There were not enough staff deployed to meet people's needs. There were a number of staff vacancies at the time of our inspection and staff on long term absence. As a result, staff sourced from a recruitment agency regularly worked at the service. The provider arranged this to cover minimum staffing levels which did not enable people using the service to access community-based activities. Therefore, people's social and leisure needs were not being met. The registered manager told us that they did not have enough staff who were able to drive the house vehicle and this meant people did not always have support to access the community.

● Furthermore, one person's care plan identified that intimate personal care should be provided by female only staff except in emergency situations. This meant that when no female staff were due to work in a day the person did not have their continence aids changed for up to 12 hours for the period when male only staff were working. The staffing rota confirmed this was sometimes the case.

● Additionally, there was a lack of consistency in the care being provided. From 1 January 2019, there had been nine different temporary (agency) staff working at the service. Including occasions when all of the staff on duty were from an agency. For example, all day on 19 January 2019, the afternoon and evenings of 20, 22, 26 January and 2 February 2019 and the mornings of 23 and 31 January 2019. All of the waking night shifts from 13 January – 2 February 2019 had been worked by agency staff, as had the 4 and 5 February 2019. The people living at the service had limited or no verbal communication and were not able to describe their needs. As a result the provider had not ensured that appropriately skilled and experienced staff were deployed to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not always ensured that staff were suitable to work at the service when they started working there. The registered manager told us that they obtained profiles from the staffing agencies which detailed the training the staff had undertaken and checks on their suitability. There were no profiles for six of the nine staff who had been sourced since the beginning of January 2019. Therefore, there was no evidence of their suitability to work with people using the service. However, following the inspection visit, the registered manager contacted us to say they had obtained profiles for all of the agency staff who were working at the service.

● The provider undertook recruitment checks on their own employees. These included a formal interview, information about employment history, references from previous employers, checks on any criminal records from the Disclosure and Barring Service, checks on their identity and eligibility to work in the United Kingdom. New staff undertook an induction to the service which included a range of training and shadowing experienced staff. This meant that the provider had ensured that their own employees were suitable to work at the service.

Preventing and controlling infection

● Staff did not always follow good practice around controlling the spread of infection. We witnessed a member of staff carrying chocolates in their hand from the lounge into another room and then back into the lounge before offering these to a person to eat. We discussed this with the registered manager who said that they would remind staff of the importance of following good infection control procedures when handling food.

● There were suitable procedures for preventing and controlling infection. The staff were provided with gloves and aprons and there were appropriate facilities for waste disposal. There were cleaning schedules which the staff followed to maintain a clean environment and equipment.

● In 2018, the service had an inspection from the Food Standards Agency and was awarded the highest level for the standard of hygiene and cleanliness in the kitchen and food storage areas.

Systems and processes to safeguard people from the risk of abuse

● The relative of one person told us, ''[Person] is safe and I do not have any concerns, they call me if anything happens.''

● The provider had systems for safeguarding people, identifying and reporting abuse. The staff had received training in this. Both support workers we spoke with were able to tell us what they would do if they suspected someone was being abused. There had not been any safeguarding alerts since the last inspection.

Assessing risk, safety monitoring and management

● The risks to people's safety and wellbeing had been assessed. There were plans to support them safely and minimise the risk of harm associated with these risks. For example, we saw assessments relating to people's physical and mental health, moving safely around the service, use of equipment, risk of falling, choking and people injuring themselves. All of the assessments included information about measures to support the person and if further action was needed by the staff. The assessments had been reviewed each month.

● There were appropriate assessments of the environment to make sure this was safely maintained. These included a fire risk assessment, regular fire safety drills, checks on equipment, maintaining safe walkways and checks on water, gas and electrical safety. Where problems were identified the staff had alerted the provider, so these could be addressed. There were individual emergency evacuation plans for people living at the service. Information about these was available on bedroom doors so the staff could easily access these in an emergency. The staff we spoke with knew how to respond in an emergency situation, however they told us they had not been trained to use some of the evacuation equipment and they did not feel

confident using this. The registered manager told us further training in the use of this was planned.

● The local authority had jurisdiction over people's finances through the Court of Protection. This meant that they were able to make sure money was spend appropriately and in people's best interests. Small amounts of money were kept at the service and used by the staff for people's personal purchases. The registered manager made regular checks on any expenditure and the records of these.

Using medicines safely

● People received their medicines as prescribed and in a safe way. The provider has suitable arrangements for the ordering, storage, administration, recording and disposal of medicines. The staff had been trained to understand these procedures and the registered manager assessed their competency at handling medicines. Records showed that people had received their medicines as prescribed. There was evidence the staff had worked with the GP, pharmacist and other healthcare professionals to make sure medicines were regularly reviewed and were appropriately prescribed.

● The staff had information about people's medicines and what these were prescribed for. The registered manager carried out regular audits of medicines storage and records.

Learning lessons when things go wrong

● The provider had systems for learning from incidents, accidents and complaints. There had not been any adverse events, such as these, at the service since the last inspection. However, the registered manager met with other managers within the organisation to share their experiences and learn from each other. They gave us an example of a recent inspection at another care home where poor staff practices were identified. As a result, the provider had ensured that all staff within the organisation were reminded of the whistle blowing procedures and encouraged to speak up if they saw something they thought should not happen.

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

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

● People's needs were not being met because essential equipment was not being properly maintained. All of the people using the service needed the support of specialist hoists to access baths and showers. The hoist used for accessing the bath was broken for over two months. Three of the people using the service could not use the shower. This meant they had not had access to baths during this period.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit, the registered manager told us that they had arranged a date in February 2019, when the housing association were going to repair the hoist.

● There are a number of recognised good practice guides and case studies which demonstrate that multisensory approaches are fundamental in working with people who have profound and multiple learning disabilities, in particular focussing on senses of touch, taste, sight, hearing and smell. There was a spare room at the service which the registered manager said they were hoping to convert to a sensory room. Work to do this had not started and the room was used for storage. The provider had recognised that people living at the service would benefit from an environment that provided support with their sensory needs but had not acted on this.

● Each person had their own individual bedroom. They had specialist equipment, such as adjustable beds and hoists in their rooms. People's rooms had been personalised to reflect their individual personalities. The registered manager showed us that they had recently supported people to purchase new furniture.

● There was some signage to keep people informed, such as a pictorial board of the staff to show who was on duty, and photographic menus. There were also signs to remind the staff about respecting people's privacy.

Staff support: induction, training, skills and experience

● The staff had not always received the support, training or information to help them understand people's sensory and communication needs or their profound and multiple learning disabilities. The staff sourced from an agency did not have opportunities to read detailed guidance about individual needs and had not

received training to equip them to provide effective care. There was limited evidence of the permanent staff receiving additional training and support in this area.

● We identified that people did not always receive personalised support to meet their needs. This was in part, due to a lack of understanding and knowledge from the staff. For example, the staff did not always respond appropriately when people were communicating a need. Records of their interactions and the support they had given people demonstrated a lack of awareness about people's communication. Intensive interaction is a technique taught to staff working with people who have limited verbal communication. This helps staff find ways to communicate with people. There was no evidence the staff had received training around this, or if they had they were not using it to support communication.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The permanent staff had undertaken a range of training in areas the provider considered mandatory. These included first aid, manual handling, fire safety, medicines management, dementia, food hygiene, health and safety, infection control, safeguarding adults and the Mental Capacity Act 2005. In addition, the registered manager had ensured the staff received training in respect of different healthcare conditions which affected the people living at the service.

● The support worker employed by the provider told us they felt supported. They said that the registered manager was approachable and they were happy to discuss their work with them. The member of agency staff also told us they felt the service was a supportive environment where the staff and registered manager communicated with each other well.

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

● All four people who lived at the service had done so for several years and moved there before the last inspection. The provider had undertaken an initial assessment of their needs and their care plans were regularly reviewed.

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

● People's dietary needs as well as their preferences were recorded in care plans. These plans included information about how people should be positioned to eat, any special equipment they needed and whether they were at risk of choking. The care plans also included reference to guidelines from healthcare professionals in relation to diet and eating.

● All meals were freshly prepared by the staff and we saw that people ate a range of different meals. The registered manager told us they had developed a four weekly menu which included people's known choices and likes. However, people were also able to ask for something different if they did not want the menu choice. The staff offered people regular drinks and snacks throughout the inspection visit and records showed that this was always the case.

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

● People's healthcare needs were recorded in well-developed care plans. There was additional information

about specific conditions to provide the staff with guidance about these and how to support people.

● The provider was acting within the principles of ''Building the Right Support'' regarding supporting people with their healthcare and they enabled people to access mainstream health services. They had developed health action plans and hospital passports. These were documents which provided healthcare professionals with information they needed to know about communicating with and supporting people during healthcare appointments.

● People were supported to access healthcare professionals such as doctors, nurses, dentists, opticians and specialists. There was documented evidence of consultation with other professionals and their guidance had been incorporated into care plans. The registered manager had organised for the dentist to offer some training for the staff about good oral hygiene.

● The staff monitored people's health each day and recorded changes in their condition. They had taken appropriate action when people had become unwell.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The provider had ensured that they had received authorisations in respect of DoLS. They regularly reviewed these and the registered manager explained the action they had taken to meet the conditions attached to one person's DoLS.

● There were records to show that different aspects of care and support had been discussed with people and how they had shown their consent to this. The care plans included detailed information about mental capacity and ability to consent to different aspects of their care. Where people were not able to consent, there was evidence the provider had followed a best interest process to make decisions with people's representatives.

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

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

Ensuring people are well treated and supported; equality and diversity

● The staff did not always ensure that people were well treated or supported. During our inspection we observed a number of interactions where the staff support was focussed on a task and not the needs and wishes of the people they were supporting.

● One person who was not able to communicate verbally, was supported to enter the lounge during the morning. The staff positioned the person in a way that their face was in direct sunlight from the window. The person was not able to move independently or readjust their position. The member of staff did not notice this and walked away from the person. After about 10 minutes another member of staff noticed the situation and moved the person to a more comfortable position.

● The staff regularly entered the lounge where three people were and did not communicate with them. This included walking up to people and wiping their faces, bringing drinks or food and not speaking and standing in front of or next to people without interacting with them.

● One person ate independently in the lounge. The staff bought the person their food and took this away but did not spend time with the person, ask about their enjoyment of the meal or attempt to make the mealtime a positive social experience. Another person was supported to eat by a member of staff. The member of staff was kind and polite when they spoke with the person, they also allowed the person to take their time and did not rush them. However, they did not speak with the person or use touch to show the person kindness and support. Another member of staff, who was in a different part of the room, kept talking to the staff member who was supporting the person and asking for their assistance. This meant that at times the staff member's focus was not on the person they were supporting. At the end of the person's meal, they moved the person to a different part of the lounge and walked away.

● Notwithstanding the examples above, the staff were calm and gentle when they spoke with people. There were also a small amount of positive interactions. For example, the staff tried to make one person laugh by making cat noises when a neighbouring cat visited the house.

Respecting and promoting people's privacy, dignity and independence

● The staff did not always respect people's independence. The care plan for one person stated that they ate independently once staff had cut up their food. The 'choking' risk assessment for this person confirmed this stating, ''[Person] uses a spoon to eat with and manages well.'' On the day of our inspection, a member of

staff did not offer the person the opportunity to eat their breakfast independently. They held the spoon and gave the person the whole of their breakfast. The registered manager observed this and made the comment that the person was being ''lazy today.'' They said this in a jokey way, and were not being unkind, but it did not take account of the fact that the person had been given no choice about this and the only reason they were not eating independently was because they had not been allowed the opportunity to.

● The provider had purchased equipment to help people to maintain their independence. This included specially designed cups and bowls, and we saw people used these. Two people were able to move independently around the service and they were not restricted in doing so.

● The staff provided support with people's personal care behind closed doors and there were signs on the doors reminding staff to knock before entering.

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

● The principles of ''Building the Right Support'' include enabling people to be consistently, meaningfully and continuously involved in decisions about their care and other needs. The provider did not always ensure this happened. The staff did not offer people choices about where they wanted to be or how they wanted to spend their time during the inspection. Records of care provided on previous days indicated that people spent much of their time doing the same thing each day.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Whilst the provider had developed comprehensive care plans, these were not always followed and the daily schedule for the staff did not include how they would meet people's identified needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● The relative of one person who we spoke with told us they were happy with the support their relative was getting but commented, ''Unfortunately, the day centre [person] went to closed down a few years ago and [they] miss that very much. [Person] does not do a lot now.''

● People did not engage in meaningful activities, opportunities to learn or develop their skills or interests or to meet their sensory needs.

● On the day of the inspection, one person was not supported to get out of bed until 10.45am. They spent the rest of the day of the inspection sitting in the hallway with the exception of when they ate lunch, when they went to the kitchen to look at the groceries being unpacked and when a cat came in the house and they played with this. The staff occasionally spoke greetings or a few words to this person but they did not engage in any meaningful communication or activities with the person for the duration of our visit.

● A second person was awake and lying on their bed until 11.22am when the staff brought the person into the lounge. The person was supported to have a drink at 11.33am and their lunch at 11.55am which lasted for 20 minutes. The person then fell asleep for the duration of our inspection. They did not participate in any activities or engagement with staff apart from when they were offering food and drink. The communication was limited to this activity.

● A third person was in the lounge for the duration of the inspection. They did not engage in any activity and communication with the staff was limited. The television was on in the room, and the person was asked once at 10.52am if they wanted to watch a different television programme to the one that was showing. The staff changed the television to a channel which it remained on for the rest of the day. The person was given colouring pens and paper, although their interest in this lasted less than five minutes. They were not offered an alternative activity, to change position or any engagement from the staff. They were brought lunch, drinks and a snack which they were left alone to eat. The staff spoke briefly when bringing food and drinks. The only other interactions from the staff were at 11.07am when one member of staff walked in and said, ''You ok [person]'', at 11.13am when a member of staff said, ''Hum good man, do you want to paint?'' and at 2.14pm when a member of staff picked up a musical instrument and shook it in front of the person for 30 seconds before putting it down again and walking away. The person spoke on several occasions, sometimes when the staff were in the room. However, the staff did not respond to what the person was saying. At one point a staff member sat next to the person, sighed loudly, got up and walked out of the room.

● The fourth person was able to move around the service independently and chose to listen to music in a specially dedicated ''music area'' in part of the lounge for the whole day. The staff had some occasional interaction with the person, but this was centred around responding to the person's request for help to change their music and around offering food and drinks.

● Furthermore, this level of activity and engagement was shown to be the norm with records of care provided recording no other activities for anyone during February 2019.

● The care plan for one person stated that they used to enjoy using the community but had refused to do this recently. However, the plan stated that staff should offer the person opportunities to go out into the community or use the garden every day. There was no evidence that this had happened. The care plan also stated they enjoyed construction toys although there was no record they had participated in any activity either in the house or in the community during January or February 2019. The reviews of care for December and November 2018 stated that they had received two aromatherapy sessions, had two visits from a relative and had taken part in two Christmas events. There were no other recorded activities. An activity timetable for the person stating that activities including visiting the library, local farm and going out for a walk were planned alongside baking, music sessions, using art and craft and music sessions. These activities had not taken place.

● The care plan for another person included information to state the person enjoyed swimming, visiting spas and shops, going bowling, taking day trips and attending a weekly social club because, ''The people there have known [person] for many years.'' A goal had been set at the beginning of November that they wanted to attend a music concert. The monthly reviews of this stated the staff were ''researching'' this. But there was no evidence any action had been taken to support the person to access those or any of their other chosen community activities.

● The care plan for a third person stated that they enjoyed playing their keyboard, construction toys, going to the community for bowling, shopping and meals out, meeting friends and attending a social club as well as art work, seeing their family and watching films. There was no evidence that they had participated in any of the community-based activities, construction or playing their keyboard in 2019. A timetable for activities also included a fortnightly coffee morning and weekly activities which included trips to the library, the local farm, the garden centre and for a drive or walk, and activities at home which included baking, board games, pottery and a music session. However, the only recorded activities other than colouring and television recorded for 2019 were three aromatherapy sessions and five visits from the person's relatives.

● We discussed our findings with the registered manager. They acknowledged that the service had failed to adequately support people to meet their social, sensory and leisure needs. They felt this was in part a staffing issue, with the lack of permanent staff at the service and lack of staff who were able to drive the vehicle and take people into the community. In addition to these problems, we observed that the staff did not provide any opportunities to support people with activities at home even though they were not occupied with other tasks, apart from a small amount of time cleaning, unpacking shopping and preparing meals.

● People's personal care needs were not always being met. Three people who lived at the service had not had showers or baths for over two months because the hoist to the bath was broken and they did not like or could not use the shower. On the 1 and 2 January 2019, the records for one person stated that they had not brushed their teeth because they had run out of toothpaste.

● People were not always supported to get up and go to bed at a time of their choosing. The registered manager told us that support with washing, dressing and support to change continence aids for one person was usually only provided by female staff. This was also recorded in the person's care plan, with the assistance of male staff for changing soiled continence aids only. They explained that when only male staff were on duty during the day, the female night workers supported the person to get washed and dressed and then put them back on their bed. Records showed that for two days in February 2019, this had been the case with the person being woken at 6.30am. In addition, this also meant that the person would not have received support to change their continence aids for up to 12 hours if only male staff were on duty during the day and they had to wait for female staff. This put the person at risk of skin damage, as well as potentially being uncomfortable. The support workers we spoke with were male and they told us that they had never needed to support the person in this area.

● People were not always given support to meet their communication or sensory needs. For example, one person's care records included a document for recording, ''What [person] says when [they] are talking or shouting to themselves during the day.'' The staff had completed this with information about things the person had said but there was no evidence that they had seen this as the person's need to communicate and in some instances their recorded response indicated they had failed to respond appropriately. For example, one entry in January 2019 stated, ''I asked [person] who [they] were talking to and [they] just stopped and looked at me.'' Another entry also in January 2019, stated, ''Asked what was wrong and then [person] stopped.'' And a third entry from October 2018, stated, ''I asked [person] who [they] were talking to as there was no one there in the lounge. [Person] would not answer me.'' The purpose of this record was not clear, although the records of individual incidents implied the staff felt there was a problem rather than responding to the person's need to communicate. There was no strategy for supporting the person in this respect and the records of these events were brief and did not include any analysis and therefore, no learning for others to support the person in the future.

● The care records for another person included records of ''Behaviour of interest.'' These records did not include any analysis or details about what had happened, how the person was supported or whether there were any triggers. The recordings included brief statements. There was no indication that the staff acknowledged the person's need to communicate. For example, one record on 4 February 2019 stated, ''[Person] has been shouting and very agitated for a while. Most of the afternoon [person] was in a very low mood.'' The logs of care provided to the person that day indicated the person had not received any stimulation or support to engage in an activity or communication. The records for three different days in January 2019 stated, ''[Person] was very vocal for no apparent reason'', ''Making sounds and shaking, when asked what was wrong [person] went into the kitchen'' and ''Really vocal at 2pm all the way through until dinner time and then calmed down and straight back into agitation – really loud.'' These records indicated that the person had not received the right support when they expressed these needs. The person's care plan did not include strategies for offering proactive support to help them express themselves or have their sensory needs met.

● The service had failed to ensure that the principles of ''Building the right support'' were being followed. In particular, people were not supported to have good and meaningful everyday lives through access to activities and services such as education, employment, social and sports/leisure activities or supported to develop and maintain good relationships outside of their immediate family, staff and others who lived at the service.

● The staff had not complied with the Accessible Information Standard, which requires services to identify, record, flag, share and meet the information and communication support needs of people with a disability

or sensory loss. Whilst there were some photographs designed to inform people about the staff on duty and menus. The staff did not use these, or any other communication aids such as objects of reference, to support people to communicate. As a result, people spent the majority of their time without any interaction.

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

● Following the inspection, the registered manager contacted us to let us know the action they had taken to address some of these areas of concern. They had ordered new activity equipment for the service, such as games and craft items and the staff were in the process of developing personalised activity plans for each person, so they could support people to take part in more structured activities.

● The registered manager told us that they had arranged a holiday for all the people living in the service and they would be going on this later in the year.

● The care planning documents for each person were comprehensive and gave clear guidelines for the staff on all aspects of caring for the person. There were personalised details about people's known preferences and how they communicated choices. There were comprehensive details about individual interventions and how best to support people to keep them safe and meet their needs. There were photographs to accompany all the guidelines and these showed staff important information about how to position people, which equipment to use, how to lay out plates and photographs showing people's preferences and their participation in different activities and tasks.

● There were specific goals for each person about the things they would like to achieve. The staff reviewed these each month and recorded people's progress in meeting the goals.

Improving care quality in response to complaints or concerns

● The provider had a suitable procedure regarding complaints. Information about this had been shared with family, friends and other stakeholders. None of the people living at the service had the mental capacity to make a formal complaint. However, the relative we spoke with told us they felt the provider would respond to concerns appropriately. There had not been any complaints or concerns since the last inspection of the service.

End of life care and support

● None of the people living at the service was receiving support at the end of their lives. However, the provider had liaised with families and other representatives to make sure people's wishes, including any cultural and religious needs, were recorded so that they would receive the right support if needed in the future.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care

● The provider did not promote person-centred, high quality care and support. People's care plans were not being followed and their needs were not always met.

● The principles of ''Building the right workforce'', outlined by Skills for Care (a national body set up to develop the adult social care workforce) include providing staff with additional skills and information when they are working with people who have learning disabilities. These skills include positive behaviour support, autism awareness and supporting people to communicate. The provider had not implemented a learning and development programme that gave the staff practical skills and underpinned the values set out in ''Building the right support.'' The staff had completed some training, but they did not have the skills to meet people's holistic needs or support them to communicate and take part in meaningful activities.

● The provider's systems for assessing and improving the quality of the service had not been operated effectively. Whist the provider had identified broken equipment and concerns regarding staffing deployment, their action to address these concerns had not been effective, and as a result people received a service which did not meet their needs.

● The provider's systems for identifying and mitigating risks had not always been effective. The provider's representatives had carried out an audit of the service at 10.30am on 9 November 2018. The audit included looking at activities. The person completing the audit had commented, ''Minibus out of use'', ''[Person] still in bed, [another person] listening to music, [third person] watching TV and having a snack.'' There was no indication that they had identified any concerns relating to this, although through our own observations we identified that there was little variety for people from the activities described by the auditor.

The above evidence indicates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The relative we spoke with told us they thought it was a good service. They commented, ''I am very happy with the care [my relative] receives. [The registered manager] has been very good and it is a weight off my

mind the care [person] receives.'' The permanent support worker who we spoke with told us they enjoyed working at the service and said, ''Now I am used to them and it feels like we are all part of a family. I really get personal satisfaction and I think it is a good home.'' The member of agency staff told us, ''I work at our places and this is among the best, the staff are good, and it is easy to work here.''

● The provider had asked stakeholders to complete satisfaction surveys about the service. These indicated the stakeholders were happy with the care and support provided. However, two different stakeholders had made comments about the lack of community involvement and activities with one comment stating, ''I would like to see more outings away from the home I am sure this would be beneficial for the residents who are normally confined to the house for weeks on end other than to attend hospital visits.'' The other comment was, ''More activities would be good – we all need variety in our week.'' However, all respondents had given positive feedback about the quality of care and the staff with comments which included, ''Staff are friendly and quality of care is good, I am always informed of any changes'' and ''The staff are always friendly and helpful.''

● The registered manager organised for meetings to discuss the service with family members and people living at the service.

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

● The registered manager had worked at the service for 12 years and was familiar with people's needs. They had a management in care qualification. However, they were about to leave the service and a replacement manager had not been arranged by the provider. The registered manager said that they thought that the provider intended to ask the deputy manager to temporarily run the service. Whilst the deputy manager had taken on additional responsibilities and knew the service well, they were also one of the staff working on the rota to provide support. The provider had already failed to deploy sufficient numbers of staff to meet people's needs and keep them safe and there was a risk that a further reduction in the staffing levels caused by the registered manager leaving would not enable the provider to make the improvements needed at the service.

Working in partnership with others

● The staff liaised with family members and other professionals when providing care for people using the service. The registered manager attended local authority organised meetings with other registered managers as well as meetings with the managers who worked for the provider.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person did not ensure that equipment used by the service provider was properly maintained. Regulation 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not ensure that systems and processes were operated effectively to assess, monitor and improve the quality and safety of the service, or assess, monitor and mitigate risks to the safety and wellbeing of service users. Regulation 17(1) and (2)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The registered person did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the needs of service users.

Regulation 18(1)