HSN Care (Bricket Wood) 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 was carried out on 01, 02 and 09 August 2018 and was unannounced. At their last inspection on 7 December 2017, the provider was found to not be meeting the standards we inspected. We rated the service overall as requires improvement. These areas of improvement were in relation to safe care and treatment, and leadership and governance. At this inspection we found that improvements had not been made and there were additional areas that continued to not meet the standards. We found breaches of regulations in relation to providing safe care, safeguarding people from harm or abuse, supporting staff, involving people in their care and overall management and governance of the service.

HSN Care (Bricket Wood) is a 'Care home.' People in care homes receive accommodation and nursing or personal care as a 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 accommodates up to 12 people. At the time of this inspection there were 11 people living there.

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

The service had three managers who were registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Following the inspection the provider was intending to remove two of the registered managers as they did not manage the regulated activity.

People were not consistently supported in a safe manner. Staff were not consistently aware of how to mitigate some risks to people's well-being. Staff were not aware of how or when to report concerns to people's safety and not all staff were able to describe how they would identify when a person was at risk of harm or abuse. Lessons learned were not shared to reduce the likelihood of people experiencing harm of poor care. People were not consistently supported by sufficient numbers of staff, although staff recruited were of good character. People's medicines were not managed or administered safely. Although people lived in a clean environment, care practises left people at risk of cross contamination.

Staff had received basic training however had not had training specific to the needs of people using the service. Staff told us they felt supported in their role, and some people's relatives felt staff were sufficiently skilled. People were not consistently supported in accordance with the principles of the Mental Capacity Act 2005, and people's verbal consent was not always sought. Staff were not consistently aware of people's nutritional needs, and people experienced a delay in being referred for specialist healthcare support, however when referred people saw the relevant professional when needed.

People were not consistently supported by staff in a respectful and kind manner. People's relatives felt neither they or the person using the service was central to the care they received. People's confidential personal information was not always secure.

People were provided with limited activities that did little to support their individual hobbies, interests or preferences. There was a complaint's process which people and their relatives knew how to use. However, people's relatives had not been confident that their concerns would be responded to.
There were systems in place to monitor the quality of the home, these were disorganised and did not effectively review the whole home in terms of the safety and quality of care provided. There were actions in place to address these areas and we saw some development, however further improvement was required. People's relatives were not all positive about the running of the home. Staff felt the management team were supportive and approachable.

The overall rating for this service remains 'Inadequate' and the service remains 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

Following the inspection CQC reviewed the concerns and took appropriate action.

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.

Care was not always provided to people in a safe manner or as recorded in their plan of care. Specialist health professional guidance was not followed.

Staff were not consistently aware of the risks to people's safety and health needs.

People were not always protected from the risk of harm, neglect or abuse.

People medicines were not managed or administered safely.

People lived in a clean environment, however some care practises did not ensure people were protected from the risk of infection.

People were not consistently supported by sufficient numbers of staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported by staff who had been trained in areas to support peoples individual needs. Competency reviews of staff were not robust.

People were not consistently supported in accordance with the principles of the Mental Capacity Act 2005.

People's dietary needs were met; however staff were not consistently aware of any specific dietary requirements or any specific guidance regarding how to assist people to eat and drink safely.

People had access to a range of health professionals when their needs changed however staff were not always quick to refer to the appropriate specialist when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always promoted.

Peoples relatives did not feel fully involved in decision relating to people's care.

People's relatives felt staff were caring in their approach but lacked leadership.

People's confidentiality was not always maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive care that responded to their needs.

People were provided with activity, but this did not support people's personal interests, age or preferences.

People and relatives were not able to share their views and opinions or raise suggestions regarding the running of the home through meetings or forums.

There was a complaint's process which relatives told us they had been reluctant to use.

Is the service well-led?

Inadequate

The service was not well led.

Systems were not in place to monitor the quality of care provided.

People relatives were not positive about the management of the service.

People's care records were not reviewed as people's needs changed and were not regularly updated

When incidents occurred the registered person had not managed the concern in an open and transparent manner, or offered an apology when things went wrong.

HSN Care (Bricket Wood)

Detailed findings

Background to this inspection

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

This inspection was prompted by concerns raised with us from people's relatives and the local authority. The information shared with CQC indicated potential concerns about the risk of unsafe care, people being placed at risk of harm, insufficient staff, poor training and support to staff and a lack of overall managerial oversight. This inspection examined risks.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We sought feedback from the local authority commissioning team and safeguarding team. We reviewed the minutes of quality improvement meetings held with the local authority and the provider, and spoke to people's relatives who had raised concerns with CQC.

The inspection was unannounced and carried out by two inspectors and a specialist advisor. The specialist advisor used had clinical experience of nursing care for people with a learning disability and epilepsy.

During the inspection we were unable to speak with people who used the service. We spoke with seven people's relatives after the inspection, five staff members, one of the registered managers the deputy manager and the quality director. We also spoke with the director of the organisation. We viewed information relating to six people's care and support and reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on and also in response to concerns raised to us by people's relatives and the local authority.

Not all the relatives we spoke with told us they felt the service was safe. One person's relative told us, "I think [Person] is safe living there, when we visit there isn't things we see to worry about, they have the right equipment and things." However, another relative told us, "As things stand I don't think [Person] is safe all the time, staff don't do the things they need to and I don't get the sense that they can manage [Person] safely. It's not that they [Staff] would intentionally do anything to put [Person] at risk they just don't know any other way." A third relative told us, "How can [Person] be completely safe? We have safeguarding meetings going on where [Person] has been neglected."

Staff told us they had safeguarding training and felt skilled and knowledgeable about this and keeping people safe from harm. However, when we spoke with staff about identifying where people were at risk and how they reported their concerns they were not clear. One staff member told us that safeguarding was about making sure the environment is safe and that every person has proper equipment in place. They also said that safeguarding was, "To avoid risk and to keep themselves and colleagues safe in the workplace." We asked staff specifically if they knew what abuse was and to give any examples. The only example one staff member could give us was physical abuse and told us, "There is a difference between a normal bruise and one from punching." We were unable to clarify how they differentiated between the two, staff were not aware that any bruise was required to be reported to the registered manager. Staff told us they would report any concerns to manager and CQC but were not consistently aware of what they would report. Staff were not aware they could also approach other external agencies such as the local authority safeguarding team. However the provider had ensured information regarding external agencies staff could report their concerns to were prominently displayed.

Various safeguarding incidents which had occurred at the service were being investigated by the local authority. These were in relation to acts of neglect and omission and related to moving and handling, continence care, medication errors and unauthorised use of people's own Motability vehicles. During this inspection we raised a further four safeguarding alerts in relation to neglect for four people, observed by the inspection team during the course of this visit.

At our previous inspection accidents and incidents were recorded, but lessons were not learned or shared. At this inspection we found incidents remained recorded but were unreported to the registered manager. We identified for one person five marks that had been sustained between 03 July and 14 July 2018. Although one of these had been explained in the incident report as banging their elbow on the car, the other four were not. The registered manager was not aware, neither was the quality director. Other examples of incidents recorded but not reported were identified, and where not all of these were potentially safeguarding concerns, they still had not been reviewed and assessed. One person's relative said, "I just want [Person] to be happy, safe and healthy. I don't know what to do, they don't listen, they don't learn when things happen. [Person] has bruise after bruise, but they don't seem to make any changes."

Staff told us that lessons learned were not routinely shared regarding safeguarding concerns, or day to day incidents, accidents. Staff spoken with were not aware of current safeguarding investigations. Where one person had been removed from the service by the persons relative because the family did not feel the person was safe, staff were not aware of the reasons, or that there were ongoing safeguarding investigations for this person.

We reported our findings to the local authority commissioning and safeguarding team.

This meant the safeguarding systems and practices did not keep people safe from harm or the risk of harm. Areas of improvement from the previous inspection had not been acted upon, and people remained at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently aware of all the risks involved when supporting people. For example, we asked one member if they could tell us which people were at risk of choking. They told us about one person, however of the three care plans we looked at we found two people were identified at risk of choking.

We observed two staff members assist two of these people to eat their breakfast. One person had clear guidance by the speech and language therapist [SALT] with regards how to safely assist the person to eat. The guidance noted that the person was to be assisted with an angled spoon, to assist them to put the food on the spoon and enable them to put the food in their mouth. The assessment instructed staff to give the person a small amount at a time to reduce the amount falling out of the front of their mouth and to prevent them from choking. We observed this person assisted by staff. Staff member sat down with person with a large bowl of cereal and banana. They used a large dessert spoon, which was full with food, and did not wait until they were sure the person had swallowed the spoonful. Staff continued with food dropping from persons mouth onto the food protector. We intervened and instructed the staff member to slow down which was then reinforced by the deputy manager, who told the staff member to slow down and reminded them the person had enough time before they were due at an appointment. This was reported to the registered manager and quality director and also the company director. The company director later told us he knew personally this person became distressed when offered small portions of food, which is why staff assisted to eat in the manner they did. When asked if they had referred this person back to SALT for reassessment, they told us they had not.

A second person was observed by the inspector in the communal lounge. The assessment and guidelines from the SALT were clear in how to support this person with small pieces of food no bigger than one centimetre, of soft consistency and to check they had swallowed their mouthful and to offer encouragement and prompting. We observed this staff member prepare sausage and bread in approximately four-centimetre squares. The bread was dry. They walked to the person, placed the food in their mouth, with no direction or prompting, turned their back and watched the television. Whilst sat watching television, the staff member was side on to the person on the arm of the sofa. The person was to their right. In a backhanded manner they moved their own outwards towards the persons mouth and without averting their gaze from the television, placed another mouthful of food in their mouth. The SALT guidance further stated that this person needed to be sat upright to eat, with their feet on the floor. This person was observed sat laid back on the sofa with their legs crossed. The staff member assisting this person told us they had worked in the service for a month, their main task was to assist this person on a one to one basis. They told us they had shadowed staff and read this person's care plan. Their approach in supporting this person did not demonstrate they had followed the guidance.

People had been assessed by a physiotherapist and exercises to maintain and improve people's muscle

were in place. However, daily records of care, and relatives feedback demonstrated this did not happen. One person's relative said, "Physically [Person] has gone backwards, gains they made under previous care providers have been lost. There are no outcomes for physical needs, no communication, no partnership working with us. [Person] has seen the physio and occupational therapist but the staff don't help them with their daily exercise. [Registered manager] was in the assessments and wrote up notes, but they still refuse to do them." A second person's relative said, "[Person] has deteriorated since being there, they are at risk of contractures. When they first moved in they moved around with a pacer, now they [Staff] just transfer from the wheelchair to the chair." People's relatives felt that staff were not equipped to effectively use the equipment people used to transfer. For example, one person's relative told us, "They can sort of use the equipment, [Person] has a bright green sling that they become agitated by. The staff and [Registered Manager] have been trying to get the OT to supply a replacement sling. I don't know where that is at."

Staff were not equipped to take people swimming. Not all the people we reviewed had an up to date risk assessment in place for this activity. Staff had not been trained to support people if they got into difficulty or had a seizure, and were not aware of how to respond if they did. When asked staff told us they would call for help if people had a seizure in the water, but were not aware of how to safely rescue the person or provide basic first aid.

People had a suite of assessments and care plans for varying complex health conditions in addition to their learning disability. Risk assessments and care plans written by health professionals such as epilepsy nurses, SALT's and occupational therapists were clear and easy to follow, Equipment that was required to keep people safe or support their health needs were in place, for example pressure relieving mattresses or epilepsy monitors attached to people's beds. However, where care plans were not written by health professionals we found they were not evidence based and unclear. For example, due to their condition one person demonstrated behaviours that were due to pain and discomfort caused by their condition. The risk assessment had been reviewed, but not based upon observations and evidence to conclude whether the persons discomfort or pain had improved. Had staff used an assessment tool to monitor and identify distress displayed by this person, the risk assessment and subsequent care plan would inform staff more robustly. For this person, who was known to have stomach problems, a care plan that directed staff when to seek medical advice was not present. This may lead to the person, who is unable to communicate having difficulty with constipation, leading to an increased risk of seizures. We found similar examples for other people living at the home at that time.

Some of the people we reviewed received their nutrition, hydration and medicines via a Percutaneous endoscopic gastrostomy (PEG). This is a tube passed into a person's stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate, for example, when people have certain conditions such as dysphagia. Care plans were not in place for the management of the PEG. Staff spoken with were not aware of how to safely manage the PEG and guidance regarding the safe positioning of people when eating due to aspiration was not available. Aspiration training and guidance for staff to identify when a person may be aspirating was also not present. Where medicines were administered via the peg, we observed the guidance was not always followed. For example, one person's PEG management noted they were to have 50ml of water flushed before and after they were administered their medicine. We asked the staff member how much water they had flushed and they told us 20ml.

Risks to people`s health and well-being were not consistently completed. Risk assessments reviewed that were completed by staff listed the risks involved and what may occur if not carried out following the management plan. The risk assessment instructed staff to ensure they were familiar with how to deliver support safely. For example it contained instructions for staff on how to cut the food and to give small amounts of food ensuring the person had finished their mouthful before offering more.

Risk assessments completed by HSN Care staff were not detailed on how staff should do the tasks they had to. For example, where people required hoisting the risk assessment said two staff were required to use the hoist with the sling. The sling size or identification number was not included in the risk assessments. Key risk assessments in areas such as risk of developing pressure wounds were in place but not reflective of the risks to the person. For example, nine of the eleven people living in the home were unable to mobilise and spent significant periods of time sat in wheelchairs, sofa's and in bed. They were considered low risk which was not reflective of their high level of risk of skin breakdown. Staff weighed people but did not use nutritional screening tool was to guide staff how to manage this.

People medicines were not managed or administered safely. We observed one staff member arranging four people's medicines onto one tray. They were left loose in four separate sections, with no way to identify what each tablet was, or who each tablet was for. Had the medicine trolley the tray was placed on been knocked or moved, there was a significant risk people would have been given medicines not prescribed to them. When we asked the staff member why they had prepared four people's medicines at once they could not answer. They told us they received training, and records confirmed they had been recently competency assessed. They acknowledged the method they used to prepare the medicine was not safe or best practise.

We found for a second person that five medicines were held in their physical stocks, but not recorded on the medication administration record. These medicines were over the counter medicines that had been brought into the home by relatives or other people known to the person. The medicines did not have the person's name written on them, and the staff member told us they did not require labelling as they were held within the persons own stocks. These medicines were for pain relief, symptoms of IBS, vitamins, and herbal medicines to aid sleep.

None of these medicines had been reviewed by the pharmacist to ensure they were compatible with current prescribed medicines for conditions such as epilepsy. It was not possible to reconcile the physical stocks of medicines held from the records kept by staff.

Where medicines were given covertly, because people may refuse the medicine or be unable to swallow, alternatives had not been sought by either the GP or pharmacist. We saw the GP authorised medicines to be given covertly, and for them to be crushed, but also in doing so made a point of noting if the medicine was crushed it was considered to be an unlicensed medicine. We spoke with the pharmacist, and no efforts had been made to find suitable alternative medicines, or look to use a suitable liquid form.

People were cared for in a clean and hygienic environment. Staff wore appropriate personal protective equipment when assisting people with personal care, and regular checks of cleanliness were carried out. However, where people were provided nutrition, hydration or medicines via the PEG, this was not carried out in a hygienic manner. We observed the syringes used to administer the feed, water or medicine via the peg to each of the people were stored in one tub. Staff explained they washed and sterilised these in a baby steriliser. This method of sterilising is not sufficient to ensure the syringes are clean and sterile. Syringes for all people being PEG fed were being stored in this tub, which meant that inevitably people were sharing the same syringe at different times. This placed people at a significant risk of infection. Staff were reminded of best practise in relation to the use and storage of the syringe. We reported our findings to the local authority commissioning team.

We identified concerns in relation to risk management, providing safe care, ensuring people received their medicines as prescribed and in a safe manner, and ensuring people were protected from the risk of infection. As a result this was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home were not consistently supported by sufficient numbers of staff. On the day of our inspection the registered manager told us they had 11 staff on duty, working in the home on a one to one basis with 11 people. They told us some of the people were due to go out for an appointment that morning, however, they required two to one support. Where two staff left the home to support people in the community, this left people remaining in the home under the assessed support hours. People's relatives views regarding staffing was mixed. One person's relative said, "[Person] has memberships to various zoo's, national trust and visits them regularly, there are staff around when I visit, so I think there are enough staff." However a second relative told us, "[Person] is 2:1 when they are out but they are not. When [Person] comes home, they have one carer. When in the car they should have two in case of a seizure there is an enabler in the back to intervene. We went out for a meal and it was just the driver. There is funding in place for a driver and extra carer." Another relative said, "All I can say is when out [Person] doesn't get the 2:1 care they [HSN Care] and social services say they will. The amount of times we have had to cover for the missing carer I lose count."

People did not always receive consistent support with their care. This was due to changes in the staff team with a third of the team leaving since the beginning of the year. Staff told us they were not assigned to work with one particular person to build relationships, but were encouraged to work across the home to get to know each person. People's relatives told us this lack of consistency did not consistently support people the way they needed to be supported. One person's relative told us, "They do have a high number of staff leaving, they are all very nice and [Person] obviously loves them all, but when they leave or [Person] has someone he doesn't know it causes [them] anxiety and upsets their routine. Routine is very, very, important and not something [Person] has had." A second relative told us, "It changes a lot and [Person] gets scared when there are strangers a round."

During the inspection the provider advised us they were about to implement a key worker scheme, where staff would also be allocated to work with particular people. This they told us would improve the consistency in care provided. The provider was also at the time of our inspection reviewing the contracted hours they provided to people, as there had been concerns raised that staffing had been underutilised. Staff we spoke with were unclear about where people required 1:1 support and where people required 2:1 support. Inevitably this resulted in people not receiving the level of support they had been assessed as needing. We requested throughout the inspection for the provider to demonstrate to us how they monitored the contracted care hours commissioned to ensure they were fully utilised, however they were unable to do so. Although they provided us with the staffing hours used for the previous two weeks this did not evidence where the contracted hours had been met. When we met the provider to give them feedback from the inspection they told us this was a piece of work they were undertaking to review all the commissioned hours.

Staff working in the service had been employed following a robust recruitment process, that involved undertaking a criminal records check, providing references of previous employment and a checkable work history. This helped to ensure people working in the service were of sufficiently good character to do so.

Requires Improvement

Is the service effective?

Our findings

One person's relative felt staff were sufficiently trained to support people effectively. They told us, [Staff] are friendly, they answer questions I ask. They seem to me to have the right training." However, the majority of relatives we spoke with felt staff did not have the required skills and experience. One person's relative said, "Don't get me wrong, their heart is in the right place, but they don't have the experience." A second relative said, "There are good staff there, ones who know how to look after people with the needs they all have. But they lack leadership, someone to show them how to care properly. I don't think they have the skills yet, but I believe if they stay long enough then they will."

Staff told us they received training and supervision from the managers. One staff member said, "I had induction training when I started. Then I worked with the girls and then the boys. I think we need more training as it is not enough to understand these people`s needs." Another staff member said, "I had training at my previous job and I have done the mandatory trainings here. I have regular supervision and we discuss people and what the issues are." A third staff member said, "I had training before, and some training now [Since employed at HSN Care] but I think I need more. These people are very special and we need very special training to help them."

The training record showed that staff had not completed their induction or care certificate training to give them a fundamental understanding of care. For example, three staff who started employment in January 2018 had not completed their induction or the care certificate, where the provider expected this to be completed within 12 weeks. The training record we looked at did not demonstrate where staff had been supported to meet people's specific needs. For example, in relation to dysphagia, risk of choking, autism or other complex health conditions. Staff had not been provided with communication training or awareness, using distraction techniques or mental health self harm awareness. Concerns were raised through our observation during the inspection regarding the effectiveness of the competency checks carried out by the management team. Where we were assured by the provider staff had their competency reviewed by management qualified to do so in areas such as medicines, personal care and safeguarding, there were significant areas of concern reported in the safe domain of this report that demonstrated the competency assessments were not effective.

We were provided with a training and development plan that addressed some of the areas of concern we identified. However, a number of these key areas remained outstanding at the time of our inspection, and had ensured people's needs were not met by staff sufficiently trained to do so effectively.

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

During our inspection we observed on numerous occasions that staff did not seek people's consent prior to assisting them. We observed staff wheel people out of the communal areas where they had eaten without seeking the persons agreement. Staff were seen to change television channels people were watching without checking or observing if people liked what they put on the TV.

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. Assessments completed by one of the registered managers did not seek to ascertain people's understanding of the decision they were required to make. Where the assessment asked the registered manager to consider what the persons view was of the decision, they recorded, 'Lacks capacity.' The same approach was present throughout the assessments, which demonstrated the views of the person or where appropriate their appointed representative had not been sought. When we showed this example to the provider, they told us not to look at further assessments as they were all completed in the same manner.

Where MCA and best interest decision assessments had been completed, we found these were not completed for all people, and did not consider their preferences or choice. For example, for three people we reviewed we could only find one decision in relation them taking part when filming took place in the home leading to them appearing in a promotional video on the provider`s website. The assessments concluded that people lacked capacity to take this decision but it was in their best interest not to miss out on this day. The views of people or their appointed representative had been sought. However although the provider had emailed people's relatives we found that the best interest process around obtaining consent had not been followed. The provider had emailed people's relatives advising of the pending filming, we saw responses from some people's relatives saying that gave consent. People's relatives then had signed the mental capacity assessment, which merely concluded the person was unable to provide their consent. The MCA record we saw were copied and typed using the exact wording for each person and had been completed on the same day. On one assessment the name on the top of the page was for one person, however the concluding statement had another person`s name. Although consent had been sought, there has been no consideration through a best interest process to determine if people themselves actually wanted to participate, or how to preserve a person's identity, dignity or privacy. Where the MCA had been copied and pasted this demonstrated the process had not been followed and consideration given for each person's choices and individual considerations. We showed this to one of the registered managers, however they were not able to explain why. The remaining two decisions were taken only by the provider. A health professional was consulted who advised to complete the MCA and Best Interest decision, but was not involved in the specific individual assessment to determine what was in the persons best interest.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that applications to deprive people of their liberty had been submitted to the managing authority and were awaiting these to be authorised. We saw that where the application had been made to deprive people of their liberty, people's relatives and advocates where needed had been consulted.

Meal times were not a social event. Staff supported people as and when they got up in the morning and prepared their breakfast as they were ready. However tables were not set and the dining area was not set out for people to recognise it was meal time. Staff told us that menus and meal choices were made by the registered managers, regardless of people's preferences. We observed lunch and saw no alternative options available for people who refused the option for that day. For example, staff did not seek to ask or show people options of what they could have for lunch and prepared cooked mushrooms, beans and salad for lunch. We observed one person chose to only eat the beans, refused the remainder and staff made no attempt to encourage or find an alternative.

Where people were supported to eat their meal, this was not carried out in a manner that supported them

appropriately. For example one person had been advised by the SALT to be prompted to eat in a manner and environment that would minimise distractions such as from the television, music or radio. We observed this person to be sat in front of the television with music playing loudly, and not focused on eating their meal. Subsequently they did not finish their meal, and staff were not observed to find a quieter place to eat, turn the television down, or offer an alternative.

People`s weight was monitored but were not reviewed in line with a nutritional screening tool to identify where people may be at risk of weight loss. People were considered to be at risk of malnutrition and we saw evidence of where the dietician had been involved. However we saw an example where the dietician stated that the weight for one person should be between forty three and fifty kilograms however the person had been recently weighed at 40 kilograms. Staff could not tell us that they had referred back to the dietician for this and were not aware this had been done. We referred our findings in relation to meeting people's nutritional needs to the local authority.

People were supported by a range of health professionals, such as GP, Pharmacist, epilepsy specialists, SALT and dieticians. However people's relatives told us people did not always see these professionals when they requested or needed to. For example, one recurring theme from relative feedback was the lack of dental appointments people attended. One person's relative told us, "His teeth were awful, covered in plaque." A second relative told us, "The dentist is another one that's not followed through, [Registered manager] is supposed to have got [Person] a referral, it's not been chased if it has then they are not telling me. I spoke to [Registered Manager] the other day about a psychologist referral. [Person] hyper ventilates a lot and it has got worse. I video chat and [Person] hyperventilates three of four times in seven minutes. They need to see a psychologist I have asked three or four times." A third relative said, "We was due to have an assessment with the nurse assessor months ago. I had to cancel that and asked [Registered Manager] to rearrange. It's still not done." To ensure that people see a health professional when needed, the provider must ensure communication and referrals are made expediently to minimise delay and potential risk of harm.

The home had been specifically designed to meet the needs of the service user group who lived there. The provider had been instrumental in designing and overseeing the building of the home, and had considered accessibility as a key factor of the design. The corridors were wide, spacious and airy, with plenty of room in communal areas and bedrooms for people to socialise and also be supported with transfers and personal care safely. The environment was nicely decorated and whilst people`s bedrooms were personalised for some of the people, communal areas were bland and clinical and did not provide a homely feel.

Requires Improvement

Is the service caring?

Our findings

People's relatives told us that staff were kind and caring. One person's relative said, "When they are there, they are sensitive, patient, and very respectful of [Person] and their choices." A second relative said, "They built a meaningful relationship with [Person]. They built up a relationship by knowing [Person]." Staff told us they liked working at the home and that they were fond of the people they supported. One health professional told us," They [Staff] do care about the service users, they try their best to get things right and provide good care, they just need some guidance from the various managers."

We observed that staff called people by their preferred name and greeted people as they saw them, however not all the staff stopped to ensure people had acknowledged their greeting. For example, a person who liked being on the floor and crawling from one area to another was greeted by several staff members when they walked past. Only one staff member took the time to make this interaction meaningful and got down on their knees, until the person nodded as a response to their question. All of the other staff who greeted this person walked past and rubbed their hand through the person`s hair, gave it a rub and little shake and said, "How are you [name of the person]. Good boy!" This was not a dignified interaction. We reported this to the provider.

Staff knocked on people's doors, and provided personal care to people in their rooms and could not be overheard. However our observations during the inspection demonstrated people's dignity was not always met. Some relatives confirmed this. One person's relative said, "It's the little things, like we come in and [Person] is wearing someone else clothes."

Staff were observed to communicate between themselves and not with the people they supported. We observed three staff members assisting three people with breakfast and none of them spoke to the people they were supporting, but spoke across the lounge to each other. Staff placed clothes protectors on people without explaining what they were doing and then pushed food into people`s mouth with no interaction until they finished their breakfast. One person was seen to have their cereal dropping from their mouth onto their clothes protector. Staff were seen to scoop this back onto the spoon and give it to the person once again. In one example, we observed staff supporting a person with their meal for half an hour with no interaction, prompting or kind words.

We did not find evidence how people were supported and enabled to maintain or gain any independence and control over their life. For example, we read in some people`s care plans that staff should support people eat independently, however staff told us, "We feed people, they can't do it themselves." Another person`s care plan detailed that staff should aim to help them maintain their mobility and to achieve this to help the person walk regularly with their frame. Staff told us that they were doing this only once a week. However, we found further examples where people were required to have daily exercises, which staff were not completing. This did not support people to maintain both their mobility, but also their independence.

We saw annual reviews took place with people's relatives and relevant health professional, but found no evidence that suggested people had been consulted about their care. There was no evidence that people

participated in any way or form in planning and reviewing the care they received. Alternative or accessible formats were not used to enable people to communicate effectively, and opportunities to use technology to involve people in their care had been missed. For example, one person's relative told us one person had a tablet. However, they told us staff did not use this, and had not done for a significant period of time. They said, "[Person] used to use their tablet, we use social media to keep in touch, but when I looked at their account, it showed it hadn't been used in months."

People's relatives gave differing views about how valued they or their relative were. One relative said, "They are pretty good, if they have any concerns they will ring me, I think they listen to what we have to say." However, the majority of relatives gave an opposing view. One relative said, "They listen to me but they don't hear me when I am talking about [Persons] health needs." A second relative said, "When we first moved [Person] in I thought it was brilliant, the managers listened to us, took their lead from us about how to care for [Person]. At first I felt that my view about my [Relative] mattered, but now my voice is lost and it doesn't feel I or [Person] matter."

All the relatives we spoke with told us the care they had been told would be provided when they moved into the home had not been provided in the manner described. One person's relative said, "The world was promised and expectations have not been managed." We was also told, "It's not what we thought it would be though to be honest, when we started with The Kestrels we thought this was a forever home, but the trust has been eroded away and now we don't know what to do, we need them to honour their promises."

Overall we found inconsistencies across the home in how staff ensured people's preferences were met, and that people and their relatives felt undervalued and not central to the care provided. Overall people's relatives did not feel involved in developing and shaping the care, and people were not always supported to be as independent as they could. Care had not consistently been provided as needed and trust had been lost in the provider. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People's relatives gave mixed responses when asked how people are supported with meaningful activity. One person's relative told us, "[Person] is very happy there, they give [Person] more than we could provide them with. They go to jazz clubs, swims, bowling, and has far more a normal life than they would have here. A second person's relative also told us, "[Person]is probably the happiest we have seen them. They are probably happy because they are not forced to do things they don't want to. They have membership to the zoo and national trust and go quite regularly I understand."

However another relative told us, "At the moment [Person] goes to the same place, the park. They are waiting on the car to be adapted, so they don't do much other than that. [Person] needs to go swimming to keep their condition stable, but hasn't gone. I said just put [Persons] harness in the back. I begged "Registered Manager" if there was any way we could get [Person] to swimming, they can get in any car with the harness, but they had not thought of that. [Person] just doesn't do much apart from visits to the park." We noted that swimming for this person was recommended by health professionals. We spoke with the provider about looking for alternative ways to get this person to their swimming classes. They acknowledged that the management team could have looked at using staff car, mini cab, or local transport schemes to facilitate this.

One person's relative told us hearing therapy was not carried out and the equipment to support their sensory impairment was not used. They told us this person became confused and agitated by normal sounds, and by using the equipment the person was able to make sense of the noises and find a sense of calm. We discussed this with the provider who acknowledged the equipment had not been used and would review.

Within the home activities were recorded in people's daily records. We saw activities were very similar and delivered ad-hoc. We could not find any schedule or routine people had other than when going swimming. Activities included: day centre, visits to a local park, disco, cinema, bowling and swimming. However, very little was done with people on a one to one basis to support their interests of individual preferences. There was no observation recorded when people carried out these activities to establish if they enjoyed these or not. We did not see initiative from staff to look for other activities people may have been able to enjoy. During our inspection people were sat with the television playing, or were laying on their bed with sensory equipment. One person's relative told us, "In the beginning they said it was assisted independent living, and [Person] would be an archetypal young person going out and doing things. They go day centre, swimming twice a week. They say they will do a lot of things in the home but end up just sitting watching TV. They take the easy option. I think that is down to management who have an idea and how they want things to be but this has not been communicated to the staff."

The provider told us after the inspection that they had supported people with engaging in activities that met their personal preferences. They told us people were supported to attend music evenings, a Jazz club and football matches, both at the live event and also watching these on television in the home. They told us people were supported to attend work experience and volunteering experiences including membership and

active participation in volunteers schemes, accessible sailing and attendance at Cricket, Ice Hockey and other sporting and recreational events including Music Festivals and cultural and religious events including. However, we were unable as part of the inspection able to verify where people had been supported in this way, and found people's relatives experiences of activity provision did not support this view.

Although people were provided with some activity within the home, this is an area that requires improvement to ensure it is tailored to the individual personality and character of the person. The provider told us the introduction of the key worker scheme would help this. They told us they would be able to match staff and people based on personality and shared interests, which would help with meeting people's social needs.

Care plans that were in place were personalised and descriptive of how people could be supported to communicate, eat, drink, be assisted with their mobility and personal care, however we did not observe staff using this information when supporting people. Staff did not use any forms of accessible communication such as sign language, pictures, non verbal expressions or refer to a communication passport to help people make decisions and have some control over what they ate, drank or what they wanted to do.

Staff told us they had no input in people`s care plans and these were done by the managers. They said they read the care plans, however when we asked about peoples` needs, likes, dislikes they could not tell us. For example, for one person the care plan detailed they liked cooked breakfast. For another person that they could point to pictures and choose what they wanted, however staff were not aware of this.

People's relatives told us there were annual reviews completed, which they attended. The effectiveness of these reviews differed. One person's relative told us, "There is an annual review that we always attend. If there are any issues we are working on those together, for example, ever since [Person] moved, there was an issue with the college who were supposed to have trained staff on how to use standing frame and walker. We couldn't get a local authority physio to help, so we got a private physio, and the Kestrels supported us to do that. They have got [Person] to get back into the pool which is important. From being nervous [Person] now goes twice a week and enjoys it very much, the staff have supported [Person] to enjoy the things they used to do." However we were also told that regardless of the reviews of the care plan, the opinions and suggestions were not taken into account.

Complaints were not consistently responded to and confidence in the management team to resolve complaints varied. One person's relative told us, "Staff had parked [Persons car] when they took them out in Sainsbury for three hours last week. They got a parking ticket, but we took it into the home and they immediately apologised and said they would pay it." A second relative said, "I have no problems raising a complaint, I go to [Director] or one of the managers." However, other relatives told us their complaints were not resolved. One person's relative said, "A year ago I bought a canopy for the wheelchair, this year they have lost it. [Team leader] think it may have fallen out of the boot of the car. No-one did anything, in the end, they lost it and I have had to take more money out of [Persons] account. We had it in writing they would replace it. [One of the registered managers] then said no. There's no consistency in management. There have been other things lost, a first aid kit, straps, they haven't looked into it when I raise it so now why bother."

Although the provider acknowledged complaints had not been robustly responded to previously, they had developed an action plan to engage with people's relatives, and also showed us examples where complaints had recently been investigated and responded to. During the course of speaking to people's relative's concerns were raised which we passed to the Quality Director. They then contacted the person and began to investigate their concern. One person's relative was positive about this change in approach. They told us,

"We had been the sole voice. We were told by HSN Care that we were the only ones bringing up these issues. I am starting to see a change. I think the change in bringing in [Quality Director] is part of that change."

Meetings were not held in the home for people's relatives to raise concerns or discuss the running of the home. One person's relative said, "Meetings, no that doesn't happen but would be good if they did, I would like to be more involved." A second person's relative told us, "I thought we were not allowed to have those type of meetings." As reported above, the newly appointed Quality Director was aware of the lack of engagement and was developing a plan to communicate more effectively with people's relatives

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found people's relatives did not all think the service was well managed, and governance systems to improve the quality of care were not effectively operated. At this inspection we found the required improvements had not been made. We also found additional areas requiring improvements in relation to providing safe care, staff training and development, obtaining consent, treating people in a dignified manner, responding to complaints, and promoting and open and transparent culture.

Staff told us that management were approachable and supportive. One staff member said, "Yes, the managers are around, we can ask questions." Some people's relatives felt the registered managers were also supportive and managed the service well. One relative told us, "I have always found that the little things we raise have been listened to, [Registered managers] are both very approachable, supportive and involved in what goes on daily." A second relative said, "The management are really excellent. We have a good relationship with [Director]. [New registered manager] has been doing a good job, and the other one assists and does an excellent job."

However this view was not shared by the remaining relatives. One told us, "I have no faith at all in any of the managers there, too many broken promises and I am thinking of moving [Person]." Another said, "The existing registered managers [They have three] two of them are not suitable, and the jury is out of the new one."

People's relatives told us they had been fearful in the past of raising concerns, and when they had they had they feared repercussions. Relatives told us that due to recent safeguarding concerns and the experience of another person and their relatives, they felt more confident and supported to raise their issues. However, all of the relatives that we spoke with were committed to resolve the ongoing issues and wanted to work in partnership with the registered manager and local authority to ensure all the people living in the home could have the care originally promised. It was striking whilst speaking to people's relatives that they felt the appointment of the new Quality Director was a positive step in improving the communication, trust and quality of care in the home.

People's care and management records were not accurately maintained, accidents and incidents were not investigated, and governance systems did not ensure the service was well led. At this inspection we found improvements had been made in relation to incident reporting and notifying CQC of events, however we found no progress made by the provider in other areas to ensure the service was well led.

Governance systems to monitor and improve the quality of care people received were not robust and not completed when needed to provide an overview of the service. The provider had completed some audits of the service; however these were not comprehensive and did not address the issues raised at this inspection. For example prior to July 2018 a regular robust review of the quality of care had not been carried out. We saw an audit was completed in April 2018, that reviewed safeguarding, complaints and compliments, staffing issues, incidents, and 'Other events' such as medication reviews, and fire drills. This audit noted no safeguarding's were open, which was inaccurate, and that a medication review had been undertaken and

actions had been set from this.

A service improvement plan had been developed and identified that medicines management was a significant issue. Targets for ensuring medicines were managed safely were in place for the end of May 2018, however we found there remained significant issues with this since the last inspection and at this inspection. This improvement plan did not include areas such as staffing, incident management, safeguarding, mental capacity assessments, peg management, nutritional and hydration care or any of the concerns identified through this inspection.

The local authority had completed a monitoring review of the service in March 2018. Areas found for improvement by the local authority were in areas such as ensuring an analysis of people's need was to be completed to ensure staff have all the required skills needed to support people. To ensure local induction is completed and documented. Safeguarding's to be reported to CQC and the local authority when suspected harm had occurred. These areas also remained outstanding with no clear plan or review against meeting these actions among many others.

The provider had advised the local authority that they had implemented a system of governance that was supplied by an external organisation. At this monitoring review it was noted this was in place, although in it's infancy of being implemented and that the registered manager need to familiarise themselves with the policy and how to use this. We found that the Quality Director had completed the first overall assessment of the safety and quality of care provided on 24 July 2018. The purpose of this was recorded as supporting the new deputy manager, reviewing medicines, discussing a new filing system and in-house checks to be implemented. It had taken the provider seven months to implement this system, regardless of our previous inspection findings and the actions set by the local authority. This audit noted staff shortages due to sickness and annual leave, outstanding care reviews, and ongoing medicines issues. This did not analyse incidents, trends emerging from incidents, safeguarding concerns or seek to review these. They had noted that a new system was due to be implemented. Although, from the July audit completed we could see the overall governance was improving, little had been achieved to this point and further development was required.

The Quality Director had reported to the board of Directors through a monthly quality report. This report was to update the board of directors on the current developments in the service. We saw that they had reported on the implementation of the safeguarding protection plan for three people. They reported that actions have either been met or were ongoing actions, however we found further issues related to these people that demonstrated the protection plan was not working and not reviewed. They reported on the Service Improvement Plan and reported most actions were complete, some were ongoing actions and others would be met the week of our inspection. We found and have noted in this report areas where issues were not met, or where they had not been identified by the provider. They also reported on the safeguarding investigations ongoing. Although they reported on the actions arising from these meetings, such as submitting evidence, they had not considered the lessons learned, or how they could mitigate future risks of those occurring again.

The service had three registered managers. At the time of our inspection, the full time registered manager was on leave. One of the part time managers had met with them prior to their leave, but did not share an action plan with the managers to ensure key priorities were followed up. The overarching view and opinion of health professionals and relatives was that the management team did not effectively communicate, meaning issues were not addressed and rolled onto the next month. When we looked at the governance, we found this was disjointed, poorly carried out and not understood by the registered management team. When we spoke with the Quality Director they acknowledged our concerns, and albeit they had begun the

process of auditing the safety of the service, agreed that a robust system was not in place, and issues from the previous inspection had not been resolved. They told us following the inspection, two of the registered managers would be de-registered, which would help with relatives knowing who is managing the service and where to address their concerns.

Care plans were locked securely in a cupboard, however staff kept personal daily records such as weight recording charts and daily monitoring charts in kitchen cupboards unlocked. Visitors to the home were able to freely access these. This meant that personal information was not kept secure and confidential

Due to the issues remaining from the previous inspection, lack of effective governance, and ongoing lack of faith in the management of the service, this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's relatives told us management had not been open and transparent with them following untoward incidents or when safeguarding concerns were raised. For example, we advised the provider of the safeguarding concerns we were raising, however people's relatives told us they had not been advised by the service of either these or any historic concerns. Duty of candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. There was no evidence in people's care records, discussions with staff or management to demonstrate where this had occurred.

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

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 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (a) (b) Dignity and respect People were not supported or treated in a dignified manner. People were not supported to be independent or part of their community.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) (g) (h) Safe Care and treatment. Care and treatment was not provided in a safe way for people using the service in a way that assessed and mitigated the risks in a manner considered to be reasonably practicable. The registered person did not ensure persons providing care or treatment had the necessary competence or skills to do so safely. Peoples medicines were not managed and administered safely. People were not protected from the risk of infections that were healthcare related.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) Safeguarding service users from abuse. Systems and processes did not ensure that people were protected from the risks of harm or abuse. Systems and processes were not operated effectively to prevent abuse of service users. Systems and processes did not effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Regulation 20 (1) (2) (a) (b) Duty of Candour The registered person did not act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. When becoming aware of a significant incident the registered person did not notify the relevant person that the incident has occurred in accordance with paragraph and did not provide reasonable support to the relevant person in relation to the incident, apologise or seek to work together to resolve the incident.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 2 (a) (b) Staffing

Staff were not provided with sufficient training that met the needs of the people they provided care and support to. Staff were not supported to develop their skills further.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 - Good governance 1, 2, (a) (b) (c) Systems or processes were not robustly established and operated effectively to assess monitor and improve both the safety and quality of care that people received. People's care records were not accurately maintained or stored securely. People's relatives did not feel they could feedback or influence how the service was managed.

The enforcement action we took:

We have imposed positive conditions on the providers registration, ensuring actions identified at this inspection are carried out as part of their conditions of registration.