Glenholme Healthcare (NGC) Limited

New Generation Care Limited - 13 Manor Crescent

Inspection report

13 Manor Crescent
Byfleet
Surrey
KT14 7EN

Tel: 01932343799
Website: www.ngcl.org.uk

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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

13 Manor Crescent provides accommodation for up to four people with learning disabilities and who may also have a physical disability. The accommodation is on one level and consists of four bedrooms with ensuite bathrooms. There were three people living in the home at the time of our inspection.

There is a care home for people with learning disabilities next door owned by the same provider. The registered manager manages both locations and all members of staff work between both houses.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance; however, the principles and values were not always being upheld. We expect that services that uphold these principles and values ensure that people living with learning disabilities and/or autism are supported to live meaningful lives that include control choice and independence. We found this was not always happening in practice.

People's experience of using this service and what we found

People were not always being protected from the risks of abuse. Safeguarding incidents were not always identified and were not notified to the local authority or CQC. Accidents and incidents were not fully investigated, and no actions were identified to mitigate the risks. There were not sufficient staff deployed to support people's needs.

Although staff received training and supervision, this was not effective in ensuring good practice within the service. People did not always receive personalised care in line with their care needs and staff did not always work with agencies to provide timely care. Care plans lacked guidance around the needs of people and when changes occurred in people's needs these were not always updated in their care plans. People did not always have access to meaningful activities.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice. For example, people had limited independence in the care they received, the activities they engaged in and the food they ate. Menus were developed by staff with no evidence of input from people who lived at the service. People were not involved in reviewing their own care or setting their own goals.

Quality assurance processes were not effective in identifying and delivering required improvements to the service which meant people were at risk of not receiving a consistent or safe service in line with their needs. The leadership needed to be more effective in ensuring staff were able to deliver the most appropriate care.

Family members told us that staff were kind and caring to their relatives. They also said staff were welcoming and communicated well with them.

The provider had systems in place to ensure safe recruitment of staff. Medicines were managed in a safe way and competency checks took place to ensure that staff were appropriately administering medicines. Staff meetings were held regularly.

Enforcement:
We have identified breaches that relate to people not being protected from abuse, risks to people were not being managed in a safe way, staff were not always following the principles of the Mental Capacity Act. There were not always sufficient staff to ensure people's needs were met, people's nutritional and hydration needs were not managed appropriately, people did not always receive person centred care and there was lack of robust effective oversight of the service.

Please see the action we have told the provider to take at the end of this report. The last rating for this service was Good (published 18 July 2016)

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Is the service effective?

Requires Improvement

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Is the service caring?

Requires Improvement

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Is the service responsive?

Requires Improvement

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Is the service well-led?

Inadequate

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

New Generation Care Limited - 13 Manor Crescent

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors carried out the inspection.

Service and type
13 Manor Crescent 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 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.

This inspection was unannounced.

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

During the inspection

People were unable to tell us about their experience. We observed the support they received and their interactions with staff. We spoke with six members of staff including the registered manager, deputy manager, regional operational manager, senior care workers and care workers.

We reviewed a range of records. This included three people's care records and medication records. We looked at one staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We spent time checking the environment.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two family members and received feedback from a healthcare professional.

Inadequate

Is the service safe?

Our findings

Systems and processes to safeguard people from the risk of abuse

● Relatives that we spoke with told us their family members were safe at the service. Comments included, "The staff are diligent in keeping [Person] safe," and "They're a lot safer than where they last were." However, despite these comments we found people were not always being protected from the risk of abuse. Safeguarding incidents were not always being recognised as such, reported or investigated appropriately. Throughout our inspection one person demonstrated behaviours that put others at risk. We saw people were aware of this person's behaviour and at times flinched when the person walked past them. On one occasion the person threw a drink over another person. Staff told us, "They (the person) are like this all the time."

● Staff were not routinely recording these incidents or referring them to the local authority as a safeguarding concern. One member of staff said, "It [recording] may not be being done as often as it should be." We saw from daily notes of another person that they had, "Deep bites on both his index fingers" that were noticed during their shower. This had not been recorded as a safeguarding concern and there was no investigation into the source of the injury. Staff told us the same person had been known to regularly leave the home without staff knowledge and had been found next door at the neighbouring service. A member of staff told us, "[Person] often leaves the building through the back door and is found next door." These incidents had not been recorded as a safeguarding concern.

● A member of staff told us they compiled information on incidents for one person which would be presented to the local authority as evidence for additional funding request. This included an incident of alleged abuse where one person had scratched another person. This had not been investigated by staff or reported as a safeguarding to the local authority.

● Although staff had received training in safeguarding and were able to tell us what they would do if they suspected abuse this training was not being put into practice. One person's behaviour support plan stated they were a risk to others and, 'Any incident involving other service users must be recorded on an incident form and inform management so that the correct safeguarding procedures can be followed.' There had been no safeguarding notifications made to the local authority or CQC during the 12-month period prior to this inspection. This was despite a member of staff telling us, "There's loads of abuse here because residents are hurting each other."

As people were not being protected from the risk of abuse this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● A care plan outlined that the person was at risk of running away from staff when in the community. However, there were no strategies in place to reduce the risk of this occurring.

● One person's health care plan identified a condition with significant associated health risks for them. The registered manager said, "It's [congenital condition] covered in different parts of their care plan." However, there was no assessment in place related to specific risks associated with this health care condition.

● Accidents and incidents were not always recorded and analysed to look for trends which meant there was little opportunity for lessons to be learned when things went wrong. Staff told us of multiple incidents where

one person frequently hit out at others. The person also attempted to grab members of the public when supervised by staff in the community. We looked at the accidents and incidents folder and noted the last recorded incident was in October 2019.

● Other staff told us they recorded this person's behaviours in an ABC chart instead of an incident form. An ABC chart is a direct observation tool used to collect information about events that are occurring within a person's environment which affects their behaviour. A member of staff told us that in addition to the ABC charts being completed, incidents forms should also be completed.

● We looked at a sample of these charts which recorded some, but not all incidents of behaviours which challenged. The charts did not contain an analysis of events leading up to the incident or recommendations for how to avoid future recurrence which would minimise risk to the person or others.

● On other occasions a person had been known by staff to frequently leave the home via the back door and had been found in the neighbouring service. Despite this known risk, sufficient action had not been taken to ensure the back gate between both properties was locked. Inspectors had reason to use this gate several times during the inspection and on no occasion was it locked.

● A fire risk assessment had taken place in 29 January 2020 with actions to be taken, some within seven days of the date of the risk assessment report. On the day of the inspection these actions had not been addressed including the removal of a combustible material on the ceiling of the sensory room. We saw a person using the sensory room on the day of the inspection despite this being a known risk. The registered manager sent an update following inspection which confirmed actions had been taken in response to the assessment.

As people were not always protected against the risks associated with their care and accidents and incidents were not always recorded and actions taken this was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People and staff at the home were not protected from the risk of infection. The home was not clean. One mop bucket and colour coded mops were stored in the laundry room. Three of these mops were hanging up and two were on the ground that were dripping and in contact with each other, increasing the risk of cross-infection.

● There was a pedal bin in the laundry room for soiled incontinence pads. We noted the lid was not properly shut and there was a strong malodour in the room. A member of staff told us, "[Bin] does work as long as staff are careful how they place the lid." They also said, "I think the [clinical waste] bin should be changed because of cross contamination."

● People's medicines were dispensed from the laundry room. We noted that dispensing cups were sitting on the draining board, next to a large bottle of fabric conditioner. There was a fridge in this room which the registered manager told us was for "Overflow food." One member of staff told us they considered this to be unhygienic, "I think we should not have food in the same area where the [clinical waste] bins are."

● The kitchen area had damaged and unclean cupboards and work surfaces. One member of staff said, "I think the kitchen is disgusting" and another said, "[Kitchen] could do with some modernisation, take the old kitchen out and put in a new one."

● There was a large piece of work top missing next to the sink and there were drink stains visible all the way down the latched gate into the kitchen. Cupboards where fresh produce was stored were visibly unclean, with one door missing and another hanging off. When we raised the poor standard of cleanliness and repair with the registered manager, they replied, "We agree the kitchen needs updating." However, they did not provide any evidence to confirm there were refurbishment plans in place.

● Carpets, paintwork and woodwork in most parts of the house were chipped, damaged and unclean. For example, there were stains on the carpet and beanbag in the sensory room. One person's toilet bowl was

stained with faeces; exposed pipes were heavily rusted, and the bottom of the bathroom door was splintered.

Premises and equipment used were not always clean, or properly maintained to reduce the risk of spreading infections. This was a breach of regulation 12 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Family members told us there were enough staff on most occasions. One told us, "They seem to have about the right number of staff most of the time." However, inspectors found there were not enough staff on shift to support people which put people at risk of harm.

● Staff told us each person had a one to one member of staff to support them between 7:00am and 9:00pm. However, they had additional tasks to do which took them away from the person they were supporting. This included responsibility for all cleaning, cooking and laundry.

● During the course of our inspection day, we saw these tasks took staff away from the people they were meant to be supporting one to one. There were several occasions when one person spent periods of time with inspectors and away from members of staff. It was only when the inspector accompanied the person back to staff (who were cooking or cleaning) that it was noticed the person was not where staff thought they were.

● In addition to the household tasks, team leaders were also required to supervise staff and do quality checks. We discussed this with the registered manager who acknowledged that the team leaders did not have enough time to carry out these additional tasks, and they [registered manager] did them instead.

● One person's care plan recorded, ''There will also be occasions when I will need 2:1 staff. For example, when out in the community.' Staff told us one person frequently left the service and was found in the service next door, "And also tries to escape from their wheelchair when in the community, I think they should be on a two to one when going out." Staff told us that at least two people required two members of staff when out in the community, "[Service user] does hit out, there should be two [staff] with them. They have grabbed a stranger down the road." The registered manager confirmed no request was made to the local authority to assess for additional staffing for these people when they went out.

● There was one member of staff at night. One person's sleep care plan recorded that, 'My sleep pattern is often irregular and/or interrupted…. I should be guided back to bed as I could disturb others……without intervention I may walk around the house at night and possibly slam doors.' A member of staff told us they thought the staffing arrangement at night was unsafe and another told us, "We need a floater [member of staff] awake during the night between both houses."

● The registered manager told us the current night time staffing levels were sufficient as people remained asleep most nights. If a person would wake up, or there was an emergency, we were told the member of staff should contact the waking night member of staff on duty next door. We also saw in daily notes that it was not unusual for at least one person to be up and about during the night.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. The provider had systems in place to ensure staff were safe to work with people before they started working at the home. Staff references were checked, and the Disclosure and Barring (DBS) was used before staff were able to work at the home. The DBS allows employers to find out if a potential staff member has any criminal convictions or they have been barred from working with adults receiving care.

Using medicines safely

● People's medicines were managed in a safe way and recorded in the Medicine Administration Record (MAR). There were no gaps in the MAR which showed that people had received their medicine.

● There was a current photograph, medical history, allergies and GP details on record.

● There was guidance for 'as and when' medicines that included the symptoms people would show if they needed pain relief and their preferred method of taking medicine.

● Medicine competency checks took place to ensure that staff were appropriately administering medicines. The first aid box was fully stocked, and all equipment was in date.

Requires Improvement

Is the service effective?

Our findings

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.

- Where decisions were being made for people, there were no evidence of decision specific assessments to determine whether they lacked the capacity to make these decisions for themselves. For example, each person was supported on a one to one basis by a member of staff. There was no assessment of the person's capacity to agree to the one to one or any evidence of the discussion to determine that this was in the person's best interest or whether less restrictive measures had been considered.
- Consent for information sharing; personal care; finance; media; room entry; administer and manage medication was noted on this person's record. There were no decision specific capacity assessments on record to support this assumption of consent.
- Another care plan recorded, "For more complex decisions I might need a group of people to make decisions on my behalf and in my best interest" and "For me to have a capacity assessment for all complex decisions." No decision specific capacity assessments were on record and staff confirmed that they were not done.
- The front door was locked because one person frequently exited it onto the street without staff knowledge. The registered manager told us there was no DoLS authorisation in place for this. Inspectors confirmed that the registered manager had not submitted an urgent DoLS request to the local authority to determine if this restriction was a legal deprivation of their liberty.
- Staff understood the main principles of MCA. One told us, "You always assume the person has capacity, they can make unwise decisions and if we do make decisions for them it's done in their best interest." They told us a DoLS application was necessary for the locked front door as it prevented people from leaving the building. However, we found they were not putting this into practice.

The requirements of MCA and consent to care and treatment were not followed which is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Adapting service, design, decoration to meet people's needs

● There was a lack of detailed assessment taking place prior to people using the service. This meant that the service could not be certain that they were able to meet people's needs.

● For example, there was no social history or background on one person's record, despite living at the service for 18 months. The registered manager told us, "We don't have a lot of background on [person]. We were not given information about them before they moved in by the local authority. I voiced our anxieties about that." However, the provider determined they were able to meet the person's needs despite not having all relevant information.

● A second assessment we looked at contained more detail but still lacked information specific to the persons background. We subsequently discovered that there was a significant piece of information which had not been updated on the person's care plan that was at the service. The registered manager showed us this was noted on the copy held in the service next door but acknowledged it should have been amended in the care plan at the service where people lived.

● People were not always supported to access healthcare services in a timely manner. The last recorded note of contact with healthcare professionals for management of anxiety and behaviours for one person was in 2017. We observed how their behaviour throughout the day impacted on people who lived there as well as on staff.

● Staff told us a health care professional visited the person nine months prior to our visit and recommended a referral was made for a review of medication to address their current behaviours. No actions were taken to refer this person for review. One member of staff told us, "It's unkind to leave them like that." Following inspection, we were informed steps were taken to, "Seek professional support for management of behaviours for [Person]."

● We saw one person was last assessed by a Speech and Language therapist in 2007, when recommendations were made. We asked the registered manager if these recommendations continued to meet the person's needs and were told, "They still stand." However, they acknowledged this was a supposition rather than based on a current assessment.

● The design and decoration of the home did not always meet people's needs. The home was sparsely decorated and there was little personalisation to make it feel like it was people's home. There were some pictures and stencils up on the living area wall which staff told us had been recently added.

● One person's bedroom was devoid of any pictures on the wall. The paintwork and woodwork were in a poor state of repair. Their care plan recorded, 'All items that can be thrown should be encased or securely attached to walls or floors.' This meant that with careful planning, this person could have a bedroom which was less clinical in appearance.

● We asked staff whether it was possible to make this bedroom less austere. One member if staff told us, "[Person's] bedroom is very sparse. They have been known to destroy things, but I haven't seen them destroy anything for ages." Another said, "We could improve the environment. You have got to make a home feel homely."

Failure to plan care and treatment around people's needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A family member told us they thought the environment was, "Appropriate to my [Relative]'s needs."

● The corridors were wide to allow easy movement of people. The garden was well maintained and fully accessible. The kitchen was open plan which could encourage people's involvement with staff to chat with people whilst they prepared meals.

Staff support: induction, training, skills and experience

● Staff told us they completed a full induction when they started at the service. They said, "I did shadow shifts and read people's care plans when I started. We had face to face and online training for the hoists."
● Although training was provided to staff this was not effective in ensuring that staff understood what they needed to do. During the inspection we found shortfalls in practices around safeguarding, MCA and the management of risks.
● We found learning was not put into practice for reporting and recording incidents of safeguarding and harm. There was poor infection control and a risk of cross contamination since mops used for different areas of the house, including bathroom areas were not kept sufficiently separated. There was a distinct lack of proper implementation of the Mental Capacity Act.
● Staff told us they had regular supervision. However, this did not have the effect of ensuring they understood key areas of their responsibilities.
● We did see that where actions were required following a supervision this was followed through. For example, one member of staff required an updated medicine competency check and we saw this had been completed.

We recommend that the provider undertakes effective competency assessments to assure themselves that staff are providing the most appropriate care to people.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always provided with sufficient hydration and nutrition to meet their needs. One care plan stated the person's weight and BMI were both, "Stable at the moment" although there was no recent weight or BMI recorded. Body Mass Index (BMI) is a measure which uses height and weight to gauge if a person's weight is healthy. We asked a member of staff if they calculated people's BMI and they said, "I can't find anything to say they are done."
● One person's care plan stated they frequently refused a main meal; however, they should be encouraged to eat snacks in between meals. We saw on the daily notes of the person that on one day they had eaten breakfast but refused lunch. They requested a snack at 17.00 but were told by staff to wait for their dinner at 19.00. This meant the person went a long period of the day without any food.
● On one occasion a person gesticulated to us which we understood to be a request for a drink. They accompanied us to the kitchen where a member of staff dismissed this request and said, "[Person] is always drinking; they have not long finished one." This person was in the company of inspectors for some time, so it was unclear as to how recently they last had a drink. Irrespective of this, their care plan did not reference any need to restrict their fluid intake.
● One person's nutrition care plan referred to a person's 'unintended' weight loss and therefore they should be weighed monthly. This was not happening, we saw they were weighed twice in a 12-month period. We raised this with the registered manager who told us, "[Person] will not stand on a weighing scales so we have just ordered a chair-scales."
● People were not engaged in menu planning. The registered manager told us there was a four-week rolling programme and when asked why there was no service user involvement they said, "We have learnt what people's likes and dislikes are, and meals reflect these."
● There was a pictorial menu on display in the kitchen. However, the meal served did not reflect what was on the menu. We asked the member of staff who cooked lunch why the planned lunch was changed. They said, "I looked at the menu and it strikes me there was a lot of carbs, so we are going to give them beans on toast." This was done without any consultation with people and the food served was also based on carbohydrates.
● Food shopping was done autonomously by staff. One member of staff told us, "We have a good knowledge of the food groups people should have. They eat what they are given." Another member of staff said, "Nine times out of ten we run out food." The registered manager said, "Sometimes we get low on food,

but we shouldn't run out - staff can go up the road to the local shop. There is a delivery due today or tomorrow, so it is good planning that we are low on food."

● Snacks and drinks were not always readily available to people during the inspection. One member of staff told us, "[Person] is likely to just eat all the snacks." However, since all those who used the service had one to one support during waking hours, this could be managed by the member of staff.

As people were not always supported with their nutrition and hydration needs this is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- We observed that staff did not always actively engage in a meaningful way with people, despite each person having an allocated one to one member of staff between 7:30am and 9:30pm. For example, one person sat in front of the television which was already on; they did not appear to select the programme which was on. Staff passed them by but did not engage beyond saying hello.
- One person was in the sensory room on numerous occasions throughout the day following episodes of challenging behaviours. Their sessions were interrupted several times by members of staff who needed to access people's records stored in a cabinet in the same room. The registered manager told us the cabinet was recently moved into the room from the next-door house to give staff easier access to the records.
- One person's nutrition care plan recorded how they actively disliked a particular sort of vegetable. We looked at their daily care notes and saw staff had recorded how the person took a long time to eat their meal as they were trying to remove the vegetable which their nutrition care plan identified as one they disliked.
- We saw few situations where people were encouraged to express their views or actively engage in decisions. For example, one person was suddenly told they were going out for a walk. This is despite their care plan stating they must be given choices and time to make their decision. Menus were drawn up entirely by staff and the meal served on the day of inspection was not what was on the menu and was changed by a member of staff.
- One member of staff told us they felt the home was institutionalised since "Routines were set for people," and said when they queried this with other members of staff, they were told, "It's the way it's always been."

As quality people were not always treated with dignity and respect, this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Important relationships were prioritised, and some families visited on a regular basis. One relative told us, "[Name] has changed beyond recognition since being here; they are so much happier than before." Another relative told us, "We think [Name] is happy here and the staff are supportive. They communicate well with us."
- One relative told us, "[Name] is supported to FaceTime me quite often so I know what is going on in their life" and "Staff are always very welcoming of me when I visit."

Respecting and promoting people's privacy, dignity and independence

● We saw when people chose to spend time in their rooms, staff respected this as their private space, including knocking before entering.
● Staff were sensitive to a person's behaviours and ensured their dignity was respected when these behaviours were demonstrated.
● A staff member told us, "We all love the guys, all the staff are really caring."

Requires Improvement

Is the service responsive?

Our findings

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Care plans contained some information on the likes and interests that people had but this lacked detail. We spoke with a member of staff about one person and they said they did not know anything about them prior to moving into the service. They said, "It would be helpful to know where they came from."

● People's identified care needs were not always regularly met. For example, one person's care plan recorded, '[Person] dislikes being surprised with activities, needs to take time to adjust to suggestions].' We heard a member of staff telling them they were going out to the shops and proceeded to assist them to get ready without giving them time to think about it. We discussed this with the registered manager who told us, "[Person] always refuses so staff tell them rather than asking." However, this approach was not defined in the person's care plan.

● Another person's care plan stated their behaviours were worse when they were under-stimulated and, "Day should be organised around calming activities." Other than the person being taken for a walk in the morning to the shop and then using the sensory room, there was no other evidence the person was received appropriate stimulation. The person displayed behaviours which challenged throughout the day.

● We were told there were currently fewer members of staff who could drive the minibus which impacted on the frequency and type of activities. One family member told us, "I know this is an issue but they [staff] usually get around it."

● Staff told us there were not enough activities, "[Person] goes out as often as we are able, but I don't think there is enough for them to do. The get bored and frustrated," and "There isn't enough stimulation, it impacts on their behaviours. I wish I could organise more."

● Staff said they hesitated to take certain people out as they felt individuals would be safer with two members of staff when in the community. They also expressed a lack of confidence at times when managing some people's behaviours in the community which put them and others at risk. "I ended up taking [Person 1] out as I am not 100% confident with [Person 2]."

As there was failure to plan care and treatment around people's needs this was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Family members told us, "[Person] is not the easiest of people to care for properly; the staff do a great job," and "[Person] has changed such a lot and for the better since moving in here."

● Staff told us about one person's particular care needs associated to their medical condition. They also said, "When they laugh, they get everyone else laughing."

● One person's care plan had good detail about a range of aspects of their care which staff were aware of and which we saw followed. A local authority professional told us their room decorated in a way which reflected their passionate interest in science fiction. Staff respected this person's wish to spend periods of undisturbed time in their room watching their favourite films.

● A local authority professional told us they confirmed that a person's risk assessments and support plans were up to date and their last review showed they were working towards and making progress.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● One person's communication care plan identified their communication was enhanced through using a handheld electronic device. We did not see it in use and asked staff about this. One replied, "They don't use it," whilst another said, "They love using it." We engaged with the person who became very excited to be handed it and began using it immediately.

We recommend there is regular engagement with person to support communication with their handheld electronic device.

Improving care quality in response to complaints or concerns
● There were no recorded complaints received at the service in the 12 months preceding inspection.
● A family member told us, "I have nothing to complain about and believe me, I would not hesitate to make my views known."
● There was a pictorial version of the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There was a lack of robust oversight from the provider to ensure and improve the quality of records and care being provided. A recent provider quality monitoring audit failed to identify issues identified by inspectors on inspection.
- For example, notification of incidents to the local authority and CQC was deemed compliant based on the one known incident recorded on the electronic record system. However, we identified incidents from reading people's daily records and staff told us of other incidents which should have been notified to the local authority. The regional manager told us, "They said, "I thought it was just significant safeguarding [which needed to be reported]."
- The audit reported that a visual check of the kitchen environment did not identify any concerns. Inspectors found damaged work surfaces and cupboards and a general lack of cleanliness in the kitchen area.
- The audit confirmed that issues identified in a person's support plan had associated risk assessments and management plans. However, we found, for example, where one person was at risk of fluctuating weight, there was no risk management plan for this, and they were not being weighed monthly in accordance with their care plan.
- The audit confirmed there was evidence of continued work with local healthcare professionals and other professionals. Inspectors found no evidence of such engagement and the registered manager confirmed they did not have continuing contact with these agencies at the time of inspection.
- The registered manager told us they monitored staff and service user interactions. They said this was done by informal observations and they did not record their observations, "It is done in a very low-key way and any concerns will be addressed in supervision and written as a file note." They could not immediately recall any instances of concern and we were not provided with any examples.
- The lines of responsibility for the day to day leadership on the floor were blurred. Team leaders were on the staff rota and expected to do the same level of support. However, they were not necessarily the shift leader on the day and staff had conflicting views on lines of delegation.
- Staff were not given the opportunity to reflect on their responsibilities to manage risk and protect people from harm because incidents were not always recorded and therefore not reviewed to understand how they might have been managed differently.
- Some staff were not confident of being listened to when raising their concerns about the safe management of people with the manager. They said they had raised concerns in relation to staffing levels when out in the community as well as about a person's behaviours and no action had been taken.
- The service did not always work closely with relevant professionals for people's complex care needs. At the time of inspection, there was no active engagement with the local community team for people with learning difficulties and inspectors were not told of any examples of working in partnership with others.

As quality checks and leadership was not always robust or effective this is a breach of regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Whilst on the inspection we identified incidents of safeguarding that had not been notified to the CQC.
● We noted in one person's notes there were several incidents recorded of them hitting other people, with no accompanying incident forms or reports submitted to the local authority or CQC.
● We found one completed incident form where one person significantly marked another. This was not submitted to CQC and we confirmed that the local authority safeguarding team were not made aware. We were told this incident form would be produced at a meeting with commissioners for a review of the person's care.

As notifiable incidents were not always being sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider told us there were no incidents in which it was necessary to apply the duty of candour. We were unclear whether this was due in part to the low recording of incidents.
● The provider did not submit statutory notifications as required. This is information about events occurring at the service, which the service is legally required to notify CQC about.
● A family member told us they were informed when incidents occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A family member told us the provider's quarterly newsletters they were kept up to date with news and activities. They said this was helpful, "Because I don't get to visit often."
● We saw a comment recorded in a relative's meeting, '[relatives] would like to thank us all for the work we have done… can see a big improvement in…appearance and happiness.'
● Staff meetings were held each month and there was a set agenda which included safeguarding, infection control and medication. We also saw there was a nominated employee of the month, and the winner received a voucher.
● We saw one person was assisted to complete a service user survey by their relatives. The survey was positive about most aspects of their care. They were unsure about how to make a complaint; who to talk to if worried and whether they were involved in their care plan. Their response to 'what the service could do better' was, 'Encourage to go out more.'
● The registered manager told us there was poor uptake of a recent staff survey, "Despite sending out many questionnaires and asking all staff to complete them." We were sent two completed questionnaires, one of which commented, '[Person] enjoys the most is supporting the service users and feeling reward and seeing them happy and having a close next [knit] team.' The other commented, 'Would like hands on training to help me do my work better please especially with residents from number 13.'
● There were mixed views from staff about whether they felt valued. One told us, "No, it's the guys [people] that keep me here." Another said, "[manager] does listen and appreciates my skills and my knowledge. I do feel valued."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that notifiable incidents were sent to CQC where required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that care and treatment was planned around people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were always treated with dignity and respect and were not always involved in the planning of their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that the requirements of MCA and consent to care and treatment was being followed.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people were always supported with their nutritional and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient suitably qualified, competent, skilled and experienced staff to support people.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people's care was managed in a safe way.

The enforcement action we took:

We issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that quality checks and leadership was always robust.

The enforcement action we took:

We have issued the provider with a warning notice.