Clover Residents Limited

New Beginnings Residential Care - 2 Dorchester Drive

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

The inspection took place on 4 September 2017 and 12 September 2017. The first day was unannounced. The second day of the inspection was arranged with the provider.

The last inspection took place on 25 April 2017 when we rated the service Inadequate in the key questions of Safe, Effective, Responsive and Well-Led. We rated the key question of Caring as Requires Improvement. We rated the service Inadequate overall and placed them in Special Measures. We found breaches of eight Regulations. Full information about the Care Quality Commissions' regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. The appeals process had not concluded at the time of the inspection of September 2017.

At this inspection we found some improvements had been made, but there were continued breaches of regulation. We found that breaches relating to safeguarding people from abuse and improper treatment, meeting nutritional needs and premises and equipment were met. We found that breaches relating to person centred care, privacy and dignity, safe care and treatment, good governance and staffing were not fully met.

New Beginnings Residential Care - 2 Dorchester Drive is a care home for up to three people. At the time of our inspection one person with a learning disability was living at the service. The person had complex needs and was not able to share their experiences of using the service with us. In addition they did not speak English as their first language. The service was managed by Clover Residents Limited, a private organisation who ran two other care homes in North West London.

There was a manager in post who had worked at the service since September 2016. They had applied to be registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Some of the practices of the staff meant that people were placed at risk. In particular, medicines were not always managed in a safe way.

The staff sometimes worked long hours alone without sufficient breaks. This put the safety and wellbeing of the person who they were supporting at risk because they may become tired and unfocussed. Although, this practice had improved since the last inspection, this issue has not been fully rectified.

The staff did not always receive appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they were employed to perform.

The staff did not always treat the person with dignity and respect.

The person was not always supported in a way which met their needs and reflected their preferences.

The provider did not always ensure that the quality and safety of the service were assessed and monitored.

The person living at the service appeared happy and comfortable. They had unrestricted access to the environment.

The provider had made improvements in some areas. These improvements included meeting three of the breaches we found at the last inspection. The safety of the environment, in particular fire safety, had improved.

The person's health needs were being met. They were able to make choices about the food they ate and their nutritional needs were being met.

The provider was acting within the principles of the Mental Capacity Act 2005.

The person had some opportunities to access the community and try new activities. However, the provider needed to consistently provide support with these in order to meet the person's needs.

The provider had improved record keeping and the way in which records were organised.

We found breaches of five of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the inspection of 25 April 2017 CQC placed the service in 'Special Measures.' The service remains 'Inadequate' and therefore remains in Special Measures.

The purpose of special measures is to ensure that providers found to be providing inadequate care significantly improve, provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. To provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

There had been improvements to the way in which staff were deployed and planned staff working patterns allowed for the staff to take sufficient breaks from work. However, the actual working patterns of staff meant that there were occasions when some staff worked long hours alone with no breaks.

Medicines were not always being managed safely.

The practices of staff meant that there were some risks to people's safety and wellbeing.

The provider had made improvements to the safety of the building and had procedures which were designed to keep people safe in the event of a fire. There had been improved audits and checks of the environment.

The provider had appropriate procedures for safeguarding people from the risks of abuse and responding to allegations of abuse.

The provider had appropriate procedures for the recruitment of staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The staff were not always appropriately skilled, competent or knowledgeable and could not effectively meet people's needs.

The provider was acting within the principles of the Mental Capacity Act 2005 and did not place any unauthorised restrictions on people.

People were supported to access health care professionals when needed.

People's nutritional needs were met.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

The staff were generally kind when speaking with people, but their interactions were not always appropriate, demonstrated a lack of empathy, were task based and limited to a few sentences at a time.

The staff did not use touch, objects of reference or any non-verbal methods of communicating or supporting communication.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People were not always cared for in a way which met their needs and reflected their preferences. However, there had been improvements since the last inspection and people were given more opportunities to try new activities and to access the community.

People's care needs were recorded in care plans.

People were supported to maintain contact with their families and the provider asked families for their feedback and opinions.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had made improvements at the service but these were not enough to ensure that the quality and the safety of the service were always assessed and monitored.

New Beginnings Residential Care - 2 Dorchester Drive

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 September 2017 and 12 September 2017. The visit on the 4 September 2017 was unannounced. We arranged the visit on the 12 September 2017 with the provider to view some records.

Both days of the inspection were conducted by two inspectors.

Before the visit we looked at all the information we held about the service. This included the last inspection report and the provider's response to this. We also looked at the record of action we had taken against the provider and the provider's response to this stating they had made improvements. We spoke with representatives from the local authority who commissioned the care of the person living at the service.

During the inspection visit we met the person living at the service, the manager and two support workers. We looked at records relating to the care of the person. We looked at staff training, recruitment and support records for four members of staff. We also looked at other records used by the staff and provider to manage the service. These included records of the hours staff had worked, rotas, medicine administration charts, health and safety checks and fire safety testing.

Inadequate

Is the service safe?

Our findings

At our inspection of 25 April 2017 we found the staff were not deployed in a safe way. The provider responded by telling us that they were addressing the issue of staff working long hours by reducing the hours of shifts worked by the staff and ensuring the staff recorded breaks taken in the staff signing in book.

During our inspection of April 2017 we had found that the staff were regularly working up to four nights and the day in a row without a break. At the inspection of September 2017 we found this practice had stopped and there had been improvements to the way in which the work was planned. However, there were still some instances when the staff worked alone for long shifts. The manager explained that the staff had found it difficult making this change and were resistant to the new system of shift planning.

We viewed the rotas for August and September 2017. These showed that staff were allocated breaks and that they were no longer booked to work excessively long shifts. However, the staff signing in records for the same period of time indicated that there were some occasions when the staff had long shifts which did not reflect the planned rota. For example, one member of staff started work at the service at 3pm on 31 August 2017. They worked that evening and the whole of the next two days including three nights where they slept at the service, without a recorded break, leaving the service during the morning of the 3 September 2017. The rota for this period showed that the member of staff had been assigned a break on 1 September 2017 from 11am until 8pm, that a different member of staff was due to carry out the sleeping in shift on 2 September 2017 and that the member of staff was not working at all on 3 September 2017. In this instance, the real hours worked by the staff had not been recorded on the rota and therefore it was difficult to assess whether rotas were always an accurate reflection of the actual hours worked.

In another example the staff signing in book indicated that a member of staff worked from 2pm on 7 September 2017 until 11am on the 10 September 2017. They carried out three sleeping duties at the service. There were no other records of staff signing that they worked during this period. The rota for these dates indicated that the person would have a break during the 8 September and that they were assigned to finish at 6pm on 9 September with a different member of staff carrying out the sleeping in shift that night. Again, we found that the rota was not an accurate representation of the actual hours worked.

There were other examples where the staff signing in book indicated that some staff had worked long hours without a break. For example, one member of staff worked from 8pm on 27 August 2017, the whole of the following day and had two sleeping shifts at the service before leaving on the morning of 29 August 2017. Another member of staff had worked from the evening of 11 August to the morning of the 13 August. The rota for this date showed a different member of staff had been assigned to carry out the sleeping in duty on 11 September 2017 and that the member of staff was due to have a break during the day time hours on 12 September 2017.

This evidence indicated that staff were sometimes working long shifts on their own without sufficient breaks. This put the safety and wellbeing of the person who they were supporting at risk because they may become tired and unfocussed.

We found evidence that the staff working at the service were sleeping on the sofa in the lounge for their night sleeping duties. One member of staff told us that they did this because they wanted to be close to the person if they were needed. They said that the designated sleeping room was too far away from the person. This sleeping arrangement could mean that they were not having a proper rest or break from their duties during this time. One member of staff told us that they were needed to support the person to use the toilet during the night duties.

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

At the inspection of 25 April 2017 we found that some people were prescribed PRN (as required) medicines. The staff had created protocols for when these should be administered. However, the documents were not fully completed and did not indicate under what circumstances the staff should administer certain medicines.

At the inspection of September 2017 we found although medicines were stored securely and appropriately, no improvements had been made to the management of PRM medicines. There were PRN protocols for two different types of medicines for the person living at the service. The protocols had not been updated since our last inspection and described the purpose of administration of these medicines as, ''To help calm down'' and ''To become less agitated.'' There was no additional information to tell the staff when it would be necessary to administer the medicines. Therefore the administration of this type of medicine was left to the judgement of individual staff members. This meant there was a risk that they would administer the medicine unnecessarily or under the wrong circumstances. In addition, we found that one of the medicines was now prescribed to be taken regularly and was no longer a PRN medicine. The protocol was still in place in the person's support records. One member of staff told us this was no longer used as a PRN medicine but this had not been clearly recorded and therefore there was a risk that staff on duty could administer this as a PRN wrongly.

On 4 September 2017 we found a box of this PRN medicine which had been dispensed in May 2016 stored in the medicines cabinet along with the supply of medicines to be administered daily. The box contained two packages of tablets and also an unlabelled loose tablet. We told the staff that this medicine needed to be returned to the pharmacist for destruction. However, on 12 September 2017 we found that the medicine was at the service and was not clearly labelled for disposal.

We looked at the medicines administration records for August 2017. There were gaps on the records where no administration details had been recorded. For example, there were no details to denote administration or otherwise for the lunch time administration of some medicines on 22, 24 and 30 August 2017 or the evening administration of some medicines on 29 and 30 August 2017.

At our inspection of 25 April 2017 we found the risks for each person had not been fully assessed and the provider had not mitigated against these risks.

At the inspection of September 2017 we found that improvements had been there had been some improvements. The manager had created risk assessments for two of the risks for the person living at the service. These risk assessments included details about the hazards, consequences, risks and control measures which the staff should follow in order to keep the person safe. The assessments were clear and appropriately detailed.
However, the actions to be taken in order to mitigate and manage risks were not always sufficient to provide guidance for the staff. For example, the person sometimes self-harmed. The person's care records and their behaviour management plan referred to this risk, although there was no specific guidance about preventing

this and supporting the person with this need. The staff we spoke with were able to tell us about this risk and how they should support the person to prevent it happening. In addition, we saw that the staff had recorded incident records when the person had self-harmed. There had been four recorded incidents in August and September 2017 and the staff had recorded additional incidents within the daily logs records. During the first day of our inspection visit, we observed that the staff did not always support the person in the way they had described to us in order to prevent the person self-harming. Therefore, more specific guidance relating to this and how the person should be supported may help the staff to better understand how to minimise the risks of the person self-harming.

The person's needs assessment form also referred to other behaviours which placed them at risk. There were no specific risk assessments in relation to these to enable the staff to better understand the risks and support the person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection of 25 April 2017 we found we could not judge whether staff had been recruited in a safe and appropriate way because there were not enough records to evidence this.

During our inspection of September 2017 we were able to view the staff recruitment records for four of the five members of staff regularly working at the service. The manager told us that the records for the fifth member of staff were held at another of the provider's service where they also regularly worked.

One member of staff had been employed in 2016. The other three had been employed several years before. We found that there were some gaps in recruitment records for these three members of staff. For example, one person had not completed details of their previous employment on their application form and another person had only one reference in place. We discussed this with the manager but we acknowledged that this recruitment had taken place many years ago and it may not be practical or appropriate to follow up this information any more. The records relating to the recruitment of the member of staff employed in 2016 were complete. However, we saw that there was some information of concern within the recruitment records. There was no evidence this had been discussed with the person, although the manager told us that it had been and they were satisfied with the person's responses. The manager agreed that they would ensure discussions such as this would be recorded in the future to evidence the action they had taken.

Some of the disclosure and barring service checks for staff had been undertaken up to five years ago by previous employers. We saw evidence that the manager had written to the staff requesting more up to date checks however these had not been placed on files. Therefore there was a risk that the provider did not have the most up to date information about the staff members' suitability to work at the service. The manager agreed to make sure up to date checks were in place.

At our inspection of 25 April 2017 we found the provider had not taken adequate steps to make sure people were safe in the event of a fire. The provider sent us an action plan telling us the improvements they would make.

At the inspection of 4 September 2017 we found that improvements had been made. The provider had commissioned an organisation to undertake a fire risk assessment of the building. They had implemented the recommendations and had carried out regular checks on fire safety equipment since the last inspection. The provider had created a personal evacuation plan for the person and the staff were aware of the fire procedure and how to support the person to evacuate in event of an emergency. In addition they had

clearly recorded the digital code for the front door on a poster near to the door so that this could be opened in an emergency. At our previous inspection we found that the kitchen door was locked preventing access to some of the emergency exits. The provider told us that this practice had stopped and we saw information for the staff telling them this. During our inspection we found that the door remained unlocked at all times.

At the inspection of 25 April 2017 we found that areas of the building were not sufficiently cleaned.

At the inspection of September 2017 we found improvements. There were some parts of the building which would benefit from further deep cleaning and dusting. The provider had identified this during their own infection control audit of 13 August 2017. However, they had not acted on this by the time of our inspection.

There was evidence that the staff undertook checks on cleanliness and infection control and that there was a cleaning regime at the service which the staff were expected to follow.

At our inspection of 25 April 2017 we found one person was being unlawfully restrained. At the inspection of 4 September 2017, the person no longer lived at the service and the staff were not using any form of restraint on the person who was living there.

There was evidence that the provider had discussed this issue with the staff whilst the person lived at the service. Copies of the staff meeting minutes from May 2017 indicated that the manager had discussed safe manual handling techniques and issued guidance so that people could be moved safely without restraining them. In addition, there was information about how to recognise and report abuse on display in the office and more detailed guidance within a file.

During the inspection of 4 September 2017 we observed hazards to the safety and wellbeing of the person who was living at the service and others. On arrival at the service we found that electrical items had been plugged into extension leads which trailed across the lounge floor from one side of the room to the other. The member of staff on duty rectified this half an hour after our arrival. However, the person living at the service and staff member had used this room before our arrival and there was a risk that they could have tripped over these cables.

There were food items which had passed the best before date in the kitchen, including a packet of daal which was best before December 2015. In the fridge there were three yoghurts which had a use by date three days before our inspection visit. There were also packages of meat, condiments and cheese which had not been labelled with the date of opening and a tub of cooked rice which had not been labelled with a date it was cooked. One of the members of staff told us that the person had a tendency to grab food from the fridge and eat this if not monitored. Therefore there was a risk that the person may take food and eat it when it was not safe to do so, or that staff may use the cooking products which were not in date to prepare meals. The out of date food items had been removed by our visit of 12 September 2017 and the staff had labelled open and cooked food in the fridge.

There were two toilets in the service. One toilet was used regularly by the person living at the service throughout out inspection on 4 September 2017. We observed that there was no toilet paper available in this toilet and no towels available for the person to dry their hands. The person's support records stated that the person required support following using the toilet and prompting with hand washing because they had habits which may result in spread of infection and poor hygiene. On two occasions the staff prompted the person to wash their hands after they used the toilet but they did not on the other occasions. During our visit on 12 September 2017 we found that there was a supply of toilet paper but no soap in this bathroom. Therefore, the provider did not have effective systems in place to assess risk to the health and safety of

people and doing all that was reasonably practicable to mitigate any such risks.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a contingency plan to be followed in event of different emergency situations. This was available for the staff. We noted that the only number for staff to call in event of an emergency was the manager's phone number. In addition, we saw that the manager was the person designated as on call every night on the rotas in August and September 2017. This meant there was a risk that the staff may not be able to receive senior support if they could not contact the manager in an emergency. The manager told us that staff were aware that in an emergency they would contact emergency services in the first instance.

Requires Improvement

Is the service effective?

Our findings

At our inspection of 25 April 2017 we found the staff were not appropriately skilled, competent or knowledgeable and could not effectively meet people's needs. A new member of staff had not been appropriately inducted and the experienced staff lacked the skills and understanding to support the people who lived at the service.

At the inspection of September 2017 we found that the staff had received some additional training and supervision. However, this was not enough to ensure they had a better understand the needs of the person who lived at the service. The staff told us they had received training in managing medicines and first aid since the last inspection. At the last inspection we found that experienced staff knew people's basic care needs but they did not demonstrate the skills or knowledge to meet people's more complex needs. People were not supported to reach their potential and followed exactly the same pattern of activities within the same environment every day. At the inspection of September 2017 we found that this was still the case. The person who lived at the service had some variation in how they spent their time, although we observed the staff supporting them did not demonstrate an understanding of their sensory and communication needs. For example, the person's care records referred to the need for staff to use objects of reference and photographs to aid communication. The staff did not do this. The person's care records referred to their need for specific sensory stimulation and support. The staff did not follow this guidance and did not demonstrate any awareness of this.

In response to our inspection report of April 2017 the provider told us that staff were undertaking vocational qualifications in care. At the inspection of September 2017 the manager told us this was no longer the case. With the exception of the manager, the staff working at the service did not have vocational qualifications and were not working towards these.

The provider had a file of training information about the staff. This included a record of the classroom based training the staff had attended. The provider had organised for training in first aid, safeguarding adults, medicines management, health and safety, the Mental Capacity Act 2005 and fire safety in 2016 and 2017. However, the records indicated that only the manager had attended all these courses. The other members of staff had attended varying amounts of this training, with three members of staff having only attended one course each.

The provider used a system of on line training for the staff from an approved social care training organisation. The manager did not have a record of the training achieved by the staff and told us that they did not have access to this information. Therefore, they could not assure themselves that the staff training was up to date and that they had learnt from these courses.

There was evidence of one team staff meeting since our last inspection. This included discussion around some of the findings at the last inspection. The staff files for three members of staff showed that they had taken part in one individual supervision meeting in 2017. One member of staff had taken part in two meetings. The records of these did not indicate that areas of concern about staff practice had been

discussed. For example, during the inspection of April 2017 we identified areas of poor practice. There was no evidence that these had been discussed with the individual staff concerned. One staff member's record of an individual meeting included the statements of ''unprofessional'' conduct with regards to standards of practice, a ''low knowledge'' of infection control procedures and ''attitude needs improving.'' However, there was no evidence about how the person would receive support to improve or additional supervision to monitor their performance. They had not attended any relevant training courses since this time. Therefore, the provider had not taken sufficient steps to ensure staff were suitable and appropriately skilled and knowledgeable.

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

At our inspection of 25 April 2017 we found the provider had placed restrictions on people's freedom without proper assessment or authorisation.

At the inspection of September 2017 we found that improvements had been made. The previous restrictions were no longer in place and the person living at the service was able to move around the environment freely. They were assigned individual support and were able to access the community when they expressed a wish to do so.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked that the provider was acting in accordance with the principles of the Act and found that they were. The provider had applied for a DoLS in respect of the person who lived at the service. There was information about their capacity to consent and who should be involved in best interest decisions about their wellbeing.

At our inspection of 25 April 2017 we found people's nutritional needs were not always being met. We made a requirement in respect of this.

At the inspection of September 2017 we found that the provider had met this requirement. The person who lived at the service was able to choose the food they wanted to eat. The staff created menus based on the person's likes and nutritional needs. However, the person was able to make different choices if they wanted. The person was encouraged to make healthy choices such as eating fruit and vegetables which were available. The person was weighed monthly.

The staff supported the person to access healthcare professionals when they needed. There was evidence that they had consultations with different healthcare professionals and that the staff had responded to changes in the person's health condition by contacting appropriate professionals.

Requires Improvement

Is the service caring?

Our findings

At our inspection of 25 April 2017 we found the staff were generally kind when speaking with people, but their interactions were not always appropriate, demonstrated a lack of empathy, were task based and limited to a few sentences at a time.

The provider responded in writing telling us that improvements had been made at the service. When we inspected on 4 September 2017 we saw that some improvements had been made although we witnessed an incident which demonstrated a lack of empathy and respect from one member of staff. In addition, both members of staff had conversations about the person which were not appropriate. Therefore we have judged that further improvements were required in this area.

The incident we witnessed and the things the staff told us about the person were discussed with the manager at the service on 12 September 2017. These were of a personal nature and therefore details are not recorded within this report.

One staff member told us that the person did not enjoy doing activities. They said, ''We are asked to do activities with [person] but that is not what they want, they just want to chat, chat, chat and eat, that is all [person] wants to do.'' They described the person ''chatting'' by telling us, ''All [person] does is chat, 'baloney, baloney, baloney'.''

The person's first language was not English and their verbal communication was also limited by their condition. The person's care records stated, ''I like to learn the English language, practice my words, listening and talking is very important to me.'' We observed the person was quite vocal and spent the majority of time initiating communication with the staff. The staff appeared to have some understanding of what the person was saying and told us about this. However, there were periods of time when the person t and staff were sitting with each other and the staff member was not paying attention to the person. For example, they were looking around the room or at their mobile phone. The staff did not always respond when the person spoke with them.

These comments and interactions indicated that the staff did not always respect the person and their feelings.

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

Apart from the above incidents, the staff were generally kind and polite to the person. The person enjoyed following the staff around the home and spent time with them when they were completing tasks such as cooking and laundry.

At our inspection of 25 April 2017 we found the staff did not use touch, objects of reference or any non-verbal methods of communicating or supporting communication.

At the inspection of 4 September 2017 we found improvements had not been made. The person's care records also stated, ''My support workers use photographs, picture cards and Makaton signing to enable me to be a more active participant and enhance my understanding.'' This was not the case during our inspection visit. We asked the staff to show us whether they had any additional communication aids. They showed us a box of picture cards and photographs which were stored in the office. These were not used during the inspection. At one point the person overheard the staff telling us that they liked to play with a football. The person went into their bedroom and collected a ball and bought it back into the room. The staff acknowledged the person had done this but did not offer to play a game until one of the inspection team started to play a game of catch using the ball with the person.

Requires Improvement

Is the service responsive?

Our findings

At our inspection of 25 April 2017 we found people's needs were not always being met. The way in which care was provided was not person centred and did not reflect nationally recognised good practice guidance. People did not participate in meaningful activities which offered stimulation or interest and did not access the community.

At the inspection of September 2017 we found that some improvements had been made. During the inspection visit on 4 September 2017 the person spent time with the staff whilst they attended to household tasks such as cleaning and laundry. The person was also involved in preparing their food, drinks and snacks. There was also evidence that the person had started to attend a community centre which provided activities and support some of the time.

When responding to our findings from the inspection of 25 April 2017 the provider wrote to us saying, ''We have encouraged all members of staff to support [person] in a productive way by participating in meaningful interaction and not to leave all interaction with [person] to [The staff member who can speak the person's first language].''

During the inspection of 4 September 2017 we found this was not always the case. The staff allowed the person to spend time with them but did not always engage in meaningful interactions. For example, from 9.50am until 11.25am the staff member and person sat together with a jigsaw puzzle in front of them. The person showed some interest in picking up the jigsaw pieces for a few minutes.. For some of the time neither the person nor the staff member showed any interest in the jigsaw puzzle and some of the time the staff member completed the puzzle. Whenever the staff member left the room or attended to another task, the person packed the puzzle away in the box. No alternative activity was offered. During the afternoon, a second staff member and the person went into the garden with a football. They kicked and threw this to each other for a few minutes, however, we observed that after a short while the staff member stopped the game and lent on the garden wall looking into the street.

We looked at the daily logs for July, August and September 2017. The records of some days indicated the person had not had any or had very little stimulating activities and experiences which met their needs. For example, on 8 July 2017 the daily log for the person stated, ''Morning personal care, chatting with staff, watching TV, playing dominoes.'' The log for both the 9 and 10 July 2017 stated, ''Morning personal care, house cleaning with staff watching TV.'' Similarly on 12 July 2017 the log stated, ''Walking around the house, dancing.'' During August 2017 the staff entries in the daily logs included more activities, however these were often repetitive, did not appear to last long and did not always meet the person's needs as recorded in their care records. The logs regularly referred to the person cleaning with staff, listening to music or playing with their ball. For example, the record of 27 August 2017 stated, ''prepared breakfast, household chores, listening to music, dominoes and jigsaw puzzle.'' With the activities on 28 August 2017 recorded as, ''Morning personal care and house cleaning with staff.''

The person's care records included a section about meaningful activities/interests. Within this section was

included, ''Colouring in and sorting shapes, playing with zips and clothing, watching [person's home nation] TV, dancing and music, Karaoke, walks, visiting Somali coffee shops, gardening and visiting Mosques outside of prayer times.'' There was evidence that the person had listened to music and danced, watched videos from the person's home nation on two occasions and had once coloured. But these activities did not take place regularly. Furthermore, the person's care records stated that they enjoyed, ''Massage, aromatherapy, yoga and reflexology'' but that these activities had stopped due to cost. The care records went on to state that staff offered hand, head and feet massages. There was no evidence that this had happened or that the provider had attempted to source other therapies which could be afforded.

The person's care records stated that the person had a sensory box which contained items they enjoyed playing with and touching. There were other references to the importance of this to prevent the person self-harming and damaging property. The sensory box was stored in the utility room and was not easily accessible to the person. During our visit the staff did not offer the person this and there was no reference to the use of this in daily logs from July to September 2017. Whilst the box contained some items the care records stated would be beneficial, there was potential for the staff to provide more items and a wider variety for the person. The lounge area was equipped with furniture and a television but there was nothing for the person to select and chose for an activity, entertainment or to meet a sensory need. They kept balls and some dominoes and dice in their bedroom which they could access but, again, there was no other items which the person could touch or play with. The care records stated that the person liked to feel and touch fabrics and items of clothing. Because of the risk of damage to their own clothes these were locked away. However, they were not offered alternative fabrics and clothing which their care plan stated they would enjoy for folding and the fastenings.

Therefore the person was not always being cared for in a way which met their needs and reflected their preferences.

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

However, we found that there were improvements since the last inspection. In particular the person had accessed the community more regularly for walks, visiting local shops and, on one occasion, to have lunch out. Records indicated that the frequency of outings had increased with three recorded outings in July 2017, 11 in August 2017 and five between the 1 and 12 September 2017. In addition records showed that the person had attended a resource centre three times in July and again in August 2017 and once in September 2017. This showed that the provider had made some improvements in the way they supported this person to offer better opportunities and more stimulation than we found at the inspection of April 2017.

There had been improvements to the design and content of the person's support plan. The manager had created a new care planning system. They had reviewed information and made sure this was recorded in a clearer way. The care records were easier to access and there was more up to date and accurate information about the person's needs. Staff reading the care plan would have a good understanding about how the person needed to be cared for and their preferences.

The care plan included information from other professionals about how to meet specific needs, for example healthcare needs and information from the psychology team.

The provider had contacted the family of the person who lived at the service and asked for their feedback. The person regularly saw their family and the provider had employed a member of staff who could speak the person's first language. This member of staff supported the person with medical appointments and liaised

with the family about important information.

The provider had a complaints procedure which was appropriate and available for stakeholders to view.

Inadequate

Is the service well-led?

Our findings

At our inspection of 25 April 2017 we found the provider had failed to assess, monitor and mitigate risks to people living at the service, had not assessed and monitored the quality of the service and had failed to act on the requirements and action we had taken at the previous inspection.

At the inspection of September 2017 we found that some improvements had been made. The provider had taken action to assess, monitor and mitigate risks. They had updated information about risks and had put in place systems to check fire safety, infection control, medicines management and health and safety. However, some of these checks had failed to identify areas of risk. For example, on the first day of our inspection we found errors with medicines management. The provider had failed to identify these. Furthermore, they had not made improvements by the second day of our inspection. In addition, the staff were following some practices which put people at risk. For example, plugging in electrical devices in an unsafe way and not disposing of out of date food. The provider had rectified these issues by the second day of our inspection, when we pointed these out to them, but their own arrangements around assessing and monitoring risks had not identified these concerns.

At the inspection of 25 April 2017 we found that the provider did not always maintain accurate and up to date records. At the inspection of September 2017 we found improvements had been made. The provider had updated records for staff and for the person who lived at the service. In addition, they had improved the accuracy and clarity of other records. However, we found some records which had not been completed, such as the person's health action plan; and some records which had not been completed correctly, such as the person's weight chart. Some records had been incorrectly filed. For example, we found one staff member's induction record in another staff member's file and parts of the person's risk assessment and care records had been misfiled so that they were not in the correct order or section of their file.

At the inspection of 25 April 2017 we found multiple breaches in all areas of the service. There was evidence that the provider had started to address these. In particular they had reviewed and updated the care records for the person who lived at the service and improved the safety of the service.

However, we found that five breaches of Regulations had not been fully met and improvements were still required in many areas of the service provision. Some of these breaches had been identified during our inspection of January 2017. The provider had faced challenges including difficulties in recruiting additional senior staff for the service. The manager shared their time between four different registered services and, without supervision, the staff at this service had sometimes failed to follow guidance and procedures.

This meant that systems and processes were not always operated effectively to assess, monitor and improve the quality and safety of the service for the person living at the home.

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

The manager told us that they felt they had sufficient oversight of the service and visited three to four times a week. They said that their visits were unannounced and at different times, and included observations of interactions between staff and the person living at the service.

The Care Quality Commission (CQC) awards rating for the performance of registered services. The law requires providers to display this rating conspicuously and legibly at each location delivering a regulated service and on their website. At the inspection of 25 April 2017 we found the provider had not displayed their most recent performance rating at the location. The provider did not have a website. The service manager told us that they had placed the inspection rating on display but said that the staff must have removed the notice and they did not know why. They showed us a copy of a letter they said had been sent to all relatives and staff to accompany a summary of the inspection report from 16 January 2017. The service manager agreed to ensure the rating was displayed again. However, on arrival at the service on 4 September 2017 we saw that the rating on display was one that we awarded on 16 January 2017 and not the most recent inspection rating which had been awarded in April 2017. We discussed this with the manager on the 12 September 2017 who agreed to display the most recent rating.