Beaconsfield Care Limited

Beaconsfield Residential Care Home

Inspection report

13 Nelson Road
Southsea
Hampshire
PO5 2AS

Tel: 02392824094

Date of inspection visit:
26 November 2018
03 December 2018

Date of publication:
14 January 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

What life is like for people using this service:
• People did not receive a service that provided them with safe, effective, compassionate and high-quality care.
• Risks to people's safety and well-being were not managed effectively and this placed people at risk of harm.
• People were not always safeguarded from abuse and incidents and accidents were not managed safely to prevent a reoccurrence.
• People's needs and preferences were not always assessed or person-centred plans developed to guide staff on how to meet people's needs.
• Staff did not complete training in meeting people's needs and this meant people were at risk of inappropriate care and treatment.
• The principles of the Mental Capacity Act 2005 were not understood and applied. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.
• People were not always treated respectfully or in a way that promoted their privacy and dignity. The service was not well-led and the governance system was ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements.
• There is more information about this in the full report.

Rating at last inspection:
The service was last rated as Requires Improvement the report was published on 22 February 2017. Following the inspection, we asked the provider to tell us the actions they would take in response to the breaches of Regulations found during this inspection

About the service:
Beaconsfield Residential Care Home is a residential care home providing personal care for up to 22 people living with a mental health condition and/or a learning disability. At the time of our inspection 21 people were living in the home who met these criteria. One person had been admitted with physical health needs.

Why we inspected:
This was a planned inspection based on the rating at the last inspection.

Enforcement:
We have told the provider to take immediate action to address some of the concerns we found. We received an action plan from the provider telling us about the actions they have taken. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Following our inspection, we raised our concerns about people's safety with the local authority safeguarding team and Fire and Rescue Service.

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Beaconsfield Residential Care Home

Detailed findings

Background to this inspection

The 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.

Inspection team:
This inspection was carried out by two adult social care inspectors.

Service and service type:
Beaconsfield Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.'

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection we reviewed information, we had received about the service. This included notifications A notification is information about important events which the service is required to tell us about by law. No notifications had been sent to CQC in the 12 months before this inspection. We reviewed the actions plans that the provider had sent to us in relation to the inspection that was carried out November 2016. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke to two people using the service, some people chose not to speak with us. We observed staff with people in communal areas of the service. We spoke with the nominated individual for the provider, the registered manager, the administrator, the maintenance worker and four care staff members. We looked at eight people's care records and the medicine records for all people. We looked at the records of accidents, incidents and complaints, audits and quality assurance reports. We also looked at staff training records for all staff, the recruitment records of three staff and the supervision and appraisal records of seven staff.

Following the inspection, we asked the provider for some further information which we received. This included follow up information on people's needs, clarification of risk assessments, information related to the fire system and the outbreak of an infectious illness in the service.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:

•Risks to people's safety and wellbeing were not always assessed recorded and staff were not always aware of these.

• Risks to people had not always been assessed, monitored or mitigated effectively. For example, one person had risks identified in a local authority assessment prior to them moving into the service. These risks were associated with their health and the potential of behaviours that could pose risks to others. Staff were not aware of the risks associated with this person's care, no assessment of these risks had been undertaken and no plans implemented to reduce these risks by guiding staff as to how to care for the person safely. The lack of risk assessment, risk reduction plans and staff knowledge exposed this person and others to the risk of harm.

• Five people living in the service were at risk of harm from falls. Three of these people had sustained a serious injury because of falls. No assessment of these risks had been undertaken and no plans had been implemented to reduce the risk of harm as a result of falls. The lack of risk management placed people at risk of harm.

• Most people were living with mental health conditions including schizophrenia, anxiety, depression, alcohol dependency, behaviours that challenged and hoarding. Appropriate assessments of the risks associated with these conditions had not been undertaken and plans to reduce any risks or ensure they could be managed if they occurred had not been developed.

• Where risks had been assessed appropriate plans had not been implemented to reduce these risks. Risk assessments identified a high risk for some people who smoked in the house. Whilst a risk assessment was in place there was no plans in place to reduce these risks for people and they did not include sufficient guidance for staff to follow for people's safety.

• Where people were living with specific physical health conditions that posed risks to them: The risks associated with these had not been assessed. For example, one person was living with a terminal illness and a history of seizures. The risks associated with this person's needs had not been assessed or plans implemented to reduce these risks. Another person was living with diabetes and risks to the person from this condition had not been assessed, with plans in place to reduce these for the person. The lack of guidance available to staff on how to support people safely meant people were placed at risk of harm

• Staff had failed to identify and act on risks when people did not return to the service. For example, we

found records which confirmed a person had not returned service all night. A staff member told us this person usually returned to the service by midnight and they would be concerned if they had not. Despite staff recognising the person had not come home, they failed to act to ensure the person was safe. Staff became aware of this person's whereabouts the following day when notified by external professionals they had come to harm. Staff had not reported this person as missing. The failure of staff to identify the risks to people when they did not return home and to act to ensure their safety meant service users will or maybe at risk of harm.

• A fire risk assessment had been carried out in October 2018 and stated that frequent evacuation drills should be completed when staffing is at is minimum to be sure that night time staffing levels were suitable to meet people's needs in the event of a fire. The last recorded night time fire evacuation was done on 14 February 2017 and the registered manager confirmed this recommendation had not been carried out. There was an increased risk of fire in the service due to people smoking and hoarding behaviour. The lack of evacuation drills when staffing was at its lowest meant service users and staff were placed at risk of harm in the event of a fire.

•The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:

• The management of medicines was unsafe.

•A system was not in place to ensure that medicines prescribed for people on an 'as required' (PRN) basis were monitored and administered safely. There were no PRN protocols in place to guide staff as to the safe use of these medicines. Records showed one person was being administered PRN medication for agitation, twice a day every day with no clear explanations to why. Daily records did not show the person had been agitated it was therefore unclear as to why this medication was given. We could not be assured people were administered their PRN medication for the reason it was prescribed. Where PRN medicines are used regularly these should be reviewed by the prescriber as they may be required as regular medicines. There was a risk the person would be given this medication they did not need to control their behaviours.

• There was no record of the medicine stock on site for those dispensed from boxed or bottled containers. It was not possible to monitor these medicines and identify and investigate concerns. There was a risk that service user's medication could be missing. We found one example which appeared to show there was missing medication and the registered manager was not able to provide explanation for this and this potential error had not been previously identified. We also found examples of excess stock which was not accounted for on people's medicines records. The system in place to manage people's medicines was not effective to ensure they were accounted for safely.

•The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

• Medicines were stored safely in a locked room or locked trolley and storage temperatures were checked to monitor this was kept at the appropriate level.

Preventing and controlling infection:

• Measures in place to assess the risk and prevent the spread of infections were not effective.

•We identified multiple concerns with infection control practices including the use of shared cloth hand towels in bathrooms; a bin with no lid where food was prepared and served; non- disposable toilet brushes in place and dirty. In addition, the environment was in a poor state of repair, meaning the ability to ensure effective cleaning was not possible. The registered manager showed us audits which were in fact cleaning records, these did not identify risks to the spread and control of infections. There had been an outbreak of an infectious illness in January 2018. Poor infection control practices meant service users will or maybe exposed to the risk of harm.

• The failure to protect people from the risks associated with the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Learning lessons when things go wrong

• Lessons were not learnt when things went wrong and changes were not made to make improvements to the care people received.

• Accident records demonstrated that people had experienced falls resulting in injury. Some people had experienced multiple falls. A post falls document was attached to the accident report. This detailed some information about the cause of the fall and steps that could be taken to prevent a reoccurrence. However, this information was not used to update care plans and risk assessment to enable learning and identify preventative actions for staff. Whilst the number of falls per month was recorded, there was no analysis of accidents to identify trends and taken remedial measures.

• Although the registered manager told us there was an incident book they were unable to locate and show us this. From reading people's daily records, we saw that incidents had occurred including behaviours that may challenge others and missing persons. There was no evidence that any investigations had taken place, analysis of why these incidents may have occurred or that measures had been implemented to reduce the likelihood of this happening again.

• Risk assessments and care plans were not always reviewed following incidents. For example, missing person procedures had not been reviewed for one person who had been missing all night, to provide clear guidance for staff on when to act. This person had fallen and sustained a serious injury but this had not been recorded as an accident and no learning had been taken from this.
•The failure to evaluate and improve practice in respect of accidents and incidents which pose risks to people's health, safety and welfare is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Safeguarding people from abuse:
• People were not always protected from abuse.

• Some practices in the service were very restrictive. For example; the kitchen was unavailable to people at times during the day and overnight; facilities for hot drinks were not available outside of the kitchen. People were not permitted at these times to make their own drinks without having to request these from staff. Communal food was locked away. Food was included in the fees paid for living in the service and this meant people could not have freedom of access to snacks and food in between meals if they chose to do so. A staff member told us that one person became anxious when they could not access the kitchen when they wanted to. It was not evident that less restrictive options had been considered to enable people to have access to

food and hot drinks when they chose. People were at risk of institutional abuse when restrictions and ritualised routines were created.

•We found the systems to safeguard service users from the risk of harm were ineffective. One person was under a Deprivation of Liberty Safeguard (DoLS), this meant they had been assessed by the local authority as unable to go out of the service without being accompanied by staff for their safety. Their DoLS application identified they were 'at risk of serious injury from an increased risk of falls if unaccompanied in the community.' Daily records showed that on 2 September 2018 staff were unaware the person had left the service. No assessment of the risk of leaving the building unsupported had been undertaken and no plan developed to mitigate the risk. Whilst out of the service on this occasion the person fell and suffered a head injury. The failure of staff to safeguard the person placed them at risk of harm.

• Staff had completed training in safeguarding adults from abuse and understood how to recognise this and the action to take if they had concerns. However, no one appeared to have recognised the institutional approach with the restrictive practices and we were not assured that all incidents which could constitute a safeguarding alert or concern were being identified by the service. This was because the system to review and monitor incidents was not effective.

• We had found that incidents were not always reported to the Care Quality Commission as required under the Regulations and we have reported on this in well-led.

•The failure to operate an effective system to prevent the abuse of service users and the use of restrictive practices without an assessment of the risk of harm posed if the restriction was not in use was a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

•Staffing:

• At our last inspection in November 2016 we found the provider had failed to deploy sufficient numbers of staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made improvements in the staffing levels at the service. Staffing levels had increased from two to three care staff in the morning and from one to two care staff in the afternoon. The registered manager told us they also provided care in the afternoon. There were two waking staff on during the night.

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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

• People's needs were not always assessed prior to moving into the service. We found examples of two people who had been admitted without a full needs assessment. For one of these people, the only information available was a medicines administration record (MAR) and a discharge summary from a hospital stay after they had moved into the service. There was nothing to indicate the person's needs were in line with the provider's statement of purpose for the service as they did not have 'Particular needs arising from mental illness or a learning disability'. This person told us they had physical health support needs. Following the inspection, the provider told us this person was moved onto an appropriate health care service.

• The lack of assessment meant the service had not recognised the needs of the person and that people's choices about their care and treatment needs were not always recorded and available to guide staff. This meant people may receive care that did not meet their needs and choice.

• The provider and registered manager did not always consider national guidance or standards. For example, the registered manager was unaware of Registering the Right Support, this is CQC guidance which sets out the good practice expectations for services supporting people with a learning disability and/or autism. The registered manager was unaware of the National Institute of Clinical Excellence (NICE) which provides a wider source of good practice guidance. We could not see that policies were based on national guidance and best practice. This meant people's care and treatment may not always be delivered in line with the guidance and standards that support effective care.

• The failure to carry out an assessment of the needs and preferences for care and treatment of service users that takes into account nationally recognised evidence based guidance was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff skills, knowledge and experience:

• At our last inspection in November 2016 we found the provider had failed to ensure that staff had the required level of competence to undertake their role unsupervised. There was no induction or appraisal systems in place and staff training was not up to date and staff did not complete training to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At this inspection we found the provider had made some improvements. An induction, supervision and appraisal system was in place and completed. A training matrix was available to show most staff had completed the training identified by the provider as mandatory. The requirements of Regulation 18 had been met.

• However, we found staff had not completed training in supporting people with hoarding behaviours, with alcohol dependence, diabetes, end of life care, and falls. We found that people with these needs were not always supported safely.

• The failure to ensure staff had the competence, experience and skills to care for people safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

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 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

• The application of the MCA 2005 was inconsistent, unclear and contradictory. Mental capacity assessments for 'daily living' had been carried out by the registered manager. These assessments were not decision specific and were unclear and contradictory. The assessment identified that people had capacity to make their own decisions but then listed areas of their life they could not make decisions about. This appeared to be the standard approach as those we looked at were all recorded the same. Despite saying people could not make decisions associated with their finances or medicines the best interest process had not been undertaken.

•The registered manager was unable to explain the assessments she had completed. She showed a lack of understanding about the mental capacity act and its application in supporting people with their rights.

• Some decisions had been made about people's care and treatment without any evidence of gaining their consent or a best interest process being followed. For example, a decision had been made to keep a person's cigarettes and give them out one at a time. The person's consent and agreement had not been gained. A decision had been made to apply for a Deprivation of Liberty Safeguard without an assessment of the person's capacity to agree to this. Their mental capacity assessment for 'daily living' stated they had capacity.

• The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• The environment was not well maintained and did not promote people's wellbeing. Some carpets were heavily stained and some areas of flooring were in a poor state of repair. A tiled bathroom floor was cracked which could mean it was not effectively cleaned. Not all steps which could cause a trip hazard were marked

as such and a broken bed was taped to a handrail in a corridor. These hazards could cause people to have an accident. A staff member told us the shower was not big enough for one person to use which meant the facilities available may not meet their needs. A decoration schedule was in place and this showed some rooms had been repainted. However, the schedule did not identify the target dates for the repainting of other rooms some of which were marked as 'high' priority. There was a proposal to refurbish the kitchen units but no target date. Some required health and safety issues had been attended to but others were listed without a target date. The premises had not been maintained or adapted to improve the quality of people's lives.
• The failure to ensure the environment was properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough with choice in a balanced diet:

• One person told us the food available was "OK" another person told us they were "eating well." People were offered a choice of food at mealtimes. People's care plans contained information on their eating and drinking needs and preferences.

• However, risks associated with people's dietary needs had not always been identified and assessed. For example, risks associated with food allergies had not been assessed for another person. Where certain food posed risks to a person's health staff were not always aware of these. We heard a staff member tell another staff member that a person could eat a food item that their local authority assessment identified could lead to health complications for them. This meant the risk to the person from a food allergy was not being safely managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff providing consistent, effective, timely care:

• People's records showed they received support from other healthcare professionals such as the doctor and mental health care professionals. The registered manager told us that staff supported people, with their consent, to these appointments to be aware of any changes in their needs.
• Information about people's healthcare needs and treatments was difficult to find as information was usually recorded in people's daily notes. This meant the on-going monitoring of health concerns or treatment was not easily accessible to enable staff to evaluate the effectiveness of treatment and act if required.

Inadequate

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were not always treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence:

• There were two shared bedrooms in the service each shared by two people. Service users were issued a contract and statement of terms and conditions which referred to 'exclusive or shared use of an allocated room'. The contract did not specify the allocated room or whether this was shared. It was not evident how people had been consulted about the choice to share a room and no evidence to suggest they had been given a choice.

• There was nothing recorded about the privacy needs and expectations of people in shared rooms. We noted that for one person in a shared room, their care plan described how their sleep pattern was disturbed meaning they were up and about at night. This person had complex needs including living with dementia, poor mobility, incontinence and a visual impairment. There was no information in the person's care plan which addressed the impact of sharing a room on them, including their need for privacy, or the other person.

• Minutes of resident meetings did not reflect that communication with people was always respectful, or that they were always treated with dignity. Records showed that people had been told for example; 'keyworkers have been chosen for you' and staff must 'round people up' who don't come down for their medication at the 'set times'. Some information was punitive in tone, for example; 'If you smoke in your room you will be evicted, sinks in rooms will be removed if people urinate in these, no food in bedroom to reduce vermin'. There was no evidence to show people had been consulted about these issues and records suggested they were just told.

• Some files containing personal information were stored in an unlocked cupboard in a communal area. This meant people's personal and confidential information could be accessed by others without the authority to do so.

• The failure to ensure people were treated with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported;

• Some people living at the service appeared unkempt. Whilst people's care plans identified their personal

hygiene needs there did not appear to be an active strategy to support people to maintain cleanliness and good personal hygiene. A member of staff told us that people did not like the size of the shower and this put them off showering. For one person the shower was not adequate for their size. Other people required prompting to wash. Whilst one member of staff told us they were using a positive proactive approach with people to encourage them to shower when we asked if this was shared by all staff they said, "Some staff more than others."

• The interactions that we observed between staff and people were friendly, for example whilst people were having lunch there was light hearted conversations between staff and residents. A staff member said, "I like to make time for each individual service user, I would make time for each and every one I like to have to have a laugh with them."

Inadequate

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

How people's needs are met; Personalised care; End of life care and support

• At our last inspection in November 2016 we found that people were not supported to engage in social activities that met their preferences and wishes. There was a lack of interaction between staff and people and a lack of stimulating or meaningful activity for people in the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In their action plan dated 9 February 2017 the provider stated they would 'develop an activity programme to meet the needs and preferences of all service users within the home'. In addition, they stated they would recruit 'an activity coordinator to lead and manage this programme'.

• At this inspection we found this had not improved and there continued to be a breach of Regulation 9. An activity coordinator was not in post. The registered manager told us they had appointed a coordinator but said "It didn't work out they only stayed in post for three weeks." Subsequently the service had developed a programme of activities which were offered each day during an hour in the morning and two hours in the afternoon. During our inspection the daily activities on offer consisted of radio, colouring, cards, table games and books laid out on tables in the dining room. We noted a couple of people engaged in an activity with staff. Staff told us there was a "low participation rate". There was no evidence that these were based on people's interests. Records were kept of people's involvement in activities, these were incomplete and entries made confirmed a low participation.

• People's care plans included some information about people's interests but lacked goals and outcomes to show people's social and activity needs were fully explored as much as was reasonably practicable or met. Residents minutes showed that people had been asked to make suggestions for activities but minutes we looked at showed people had not contributed any ideas to these meetings. One member of staff told us a questionnaire had been attempted with people to find out about their interests but this exercise had not been completed and there was no evidence of this in people's records.

• Care plans were not always developed to ensure that staff understood people's personal needs and preferences. Two people living at the service did not have a care plan in place. There was no information about their needs and preferences meaning staff did not have guidance to help them deliver appropriate and person-centred care. It was not evident that these people's needs had been either fully assessed or communicated to staff. For example, Staff had entered a person's room without their permission which was identified as a trigger to aggressive behaviour in their local authority needs assessment. This person had a known risk for displaying aggressive behaviour if their needs were not met in a sensitive and specific way, including their communication needs. There had been a failure to assess this person's needs or design their care and treatment with a view to meeting their needs and ensuring their preferences were met.

• For other people care plans did contain personalised information about the person but lacked guidance about how they should be supported. They were not always up to date and based on people's current needs. For example; although a person had experienced behavioural changes over weeks because of a medication change there was no updated care plan to monitor and meet this person's changed needs.

•Needs assessments and care plans did not show that people's needs in relation to any protected characteristics under the Equalities Act 2010 had been identified or assessed.

• People's care plans did not include their preferences and choices for end of life care.

•One person had a condition which was life limiting. However, they did not have a care plan or risk assessment in place to assess and manage their needs in relation to either this condition or their end of life care needs, including pain relief. The person was experiencing pain and this had been responded to at the person's request, by the service arranging for a GP to assess.

•Despite supporting a person with a life limiting condition, the provider did not have an end of life policy care policy to guide staff and only two staff members had completed palliative care training but this was in 2009.

•The lack of policy, guidance and person-centred care planning for people's end of life care needs meant people could be at risk of not being supported to have a comfortable, dignified and pain-free death.

• The failure to provide care and support that met people's needs and preferences was a continued breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:

• Although a complaints policy was in place we could not see that complaints were always, identified, investigated or acted on to make improvements to the service people received.

•A complaints book showed two complaints had been received from people living in the service. It was not clear how one of these complaints had been resolved as the person became angry prior to a resolution being achieved. Another person was reassured by staff informing them they would take action on their complaint. The complaints book did not detail the actions taken in response to these concerns, by whom or by when and the outcome.

• We found a record of a complaint that had not been recorded in the complaints book. The complaint was from a member of the public and the record showed the registered manager had responded verbally to the complainant and informed them of the action they would take. There was no record of the actions taken in response to the complaint and no record of whether the complaint had been resolved. This meant that there was no system in place to see how people's concerns had been addressed or to understand any emerging themes or patterns of people's concerns.

•We saw that another social care professional had raised a concern on behalf of a person about the care of this person. This had been recorded in their daily records but not recorded as a complaint. Although the registered manager told us they had spoken to the person about this matter, this was not recorded in the complaints book. It was not evident how information from this complaint had been used to make improvements to the service the person received.

•The failure to effectively operate a system for identifying, receiving, recording handling and responding to complaints by service users and others was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff understand quality performance:

• At our inspection of 16 November 2016, we found the provider had failed to ensure good governance in the service. There was no quality assurance system in place, audits were not completed, policies and procedures were not dated or available to staff and guidance on meeting the regulations was not available in the service. At this inspection, this had not improved and remained a breach of Regulation 17.

•The provider's action plan dated 9 February 2017, said 'all policies and procedures would be reviewed in accordance with current legislation and dated. We found polices had been reviewed, however, there were a number of polices that were not available to provide guidance to staff. These included; end of life care, safe recruitment, pre- admission assessment and admission, duty of candour and incident reporting. This meant guidance was not always available to staff and we found current legislation and best practice was not always followed.

• In their action plan dated 9 February 2017, the provider told us 'new audit tools would be developed to reflect on the quality of the service provided. However, audits were not in place to monitor and evaluate the quality and safety of care plans and risk assessments; Medicines audits were not effective and did not identify the concerns we found; there was a check that cleaning was completed but this did not identify the shortfalls with infection control measures that we identified.

•The nominated individual for the provider told us they did not carry out any audits of the service when they visited. They were unaware of the concerns we found until we pointed these out to them. This meant there was no effective system being operated to identify the concerns we had found in relation to the health, safety and quality of the service and to make necessary improvements.

• The failure to ensure an effective system to assess and monitor the service and improve the quality and safety of the service was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection in November 2016 the provider submitted an action plan and told us they would 'undertake a full audit of all service users risk assessments to establish the level of service users' needs and assistance requirements to provide adequate staffing'. We asked the registered manager whether the staffing levels had been calculated to consider people's needs. They told us "That is what (the provider) said we could have." They were unable to show us any audit or calculation of staffing levels. Due to the lack of

detailed risk assessment it was not clear whether there were sufficient staff to meet people's needs. A staff member said "(sufficient staff levels) Varies depending, I do a lot of showers. A lot are independent but need more help than they let on."

•We recommend the service seek advice and guidance from a reputable source, about the calculation of staffing levels to meet people's assessed needs.

Leadership and management; Managers understand risks and regulatory requirements; Continuous learning and improving care:

Leadership in the service was poor because they did not understand the regulatory requirements or risk.

• The providers action plan action plan dated 9 February 2017 said the registered manager would be 'engaged in full training and development to understand current legislation. The registered manager told us they had attended a workshop about CQC's key lines of enquiry but had not undertaken any other legislation specific training.

• CQC require registered persons to notify us of significant events that occur in the service. These are incidents that enable CQC to monitor the service and analyse any risks that might be arising. We identified four incidents which should have been notified to us. These incidents related to three serious injuries sustained by people using the service and the authorisation of a Deprivation of Liberty Safeguard (DoLS).

• The failure to notify the CQC was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009

• The registered manager had failed to understand the requirements around recruiting staff. At our last inspection in November 2016 we found the provider had failed to operate safe recruitment procedures. At this inspection we found improvements had been made. However, the provider's application form did not ask candidates for a full employment history as required under Schedule 3 of the Health and Social Care Act. When asked about this the registered manager said the applications forms were using too much paper so they had shrunk this down by removing the employment history section. One person recruited following the last inspection had no employment history, and had started work prior to a second reference being received. The registered manager told us they were assured of their character because they were related to her. Without the required checks being made prior to employment meant people could be at risk of being supported by unsuitable staff.

• The failure to ensure that recruitment and selection procedures comply with the requirements of Schedule 3 was an ongoing breach of Regulation 19 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

• Throughout the inspection the registered manager demonstrated a lack of understanding of the legislation and regulations. For example; the registered manager was not aware of duty of candour and when asked what their understanding of this was, said, "I haven't understood it to mean a lot". A system was not in place to investigate and analyse incidents that had resulted in harm to people to identify if the Duty of Candour applied. The registered manager demonstrated a lack of understanding of how to apply the Mental Capacity Act 2005 or Equalities Act 2010. They were not aware of 'registering the right support' which is guidance for care services supporting people with a learning disability or autism. They lacked an understanding of effective risk management and care planning.

• There was no improvement plan in place. The provider visited on a weekly basis to meet with the registered manager and the provider told us they looked at "the environment, staffing and activities, staff sickness and training". However, the finding of these visits was not recorded to show that any actions agreed were monitored for completion. The provider was unaware of the concerns that we found. This meant the concerns about the safety and quality of the service were going unnoticed and placed people at risk of harm.

• The breaches of regulations found at the inspection in November 2016 remained breaches at this inspection and new breaches were also found. This demonstrated learning and improvement had not taken place. The provider had failed to act on recommendations regarding promoting equality and diversity and developing a personalised activity programme that were made by CQC at the last inspection in November 2016.

Engaging and involving people using the service, the public and staff

• In their action plan dated 9 February 2017 the provider stated 'a quality assurance programme would be put in place to benefit everyone within the service and which would detect shortfalls at an early stage. At this inspection we found feedback surveys had been completed in November 2017. There was no analysis of the feedback and the results were not displayed or recorded as responded to. Residents meetings were held, however the minutes of these did not reflect that people actively participated in giving feedback. The tone of these meetings appeared to be that people were told about decisions made rather than encouraged to participate in an evaluation of the service they received. The system for seeking feedback to improve the service was ineffective.