Chuhan Limited

Ormidale House

Inspection report

41 Wood Green Road
Wednesbury
West Midlands
WS10 9QS

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19 March 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 and 19 March 2018, the first day of our visit was unannounced. The inspection was brought forward earlier than planned due to concerns we had received from a staff member.

At the last inspection in June 2017, the service was rated as Requires Improvement with two breach in regulation. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Safe, Effective, Responsive and Well-Led to at least good.

At the last inspection in June 2017, we asked the provider to take action to make improvements for the safety of the premises and their governance systems. We found the action had been completed regarding the safety of the premises, however the providers governance systems were ineffective.

At this inspection we found the service was inadequate overall, and in the key questions safe, effective and well-led. The inspection identified six breaches of regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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.

Ormidale House 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.

Ormidale House accommodates 10 people in one adapted building over two floors. There were eight people living at the home on the day of our visit.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. We found the provider had not always ensured they adopted this approach, as care and support was not always person-centred, planned, proactive and coordinated.

People who lived at Ormidale House have varied and complex needs. The provider was not clear in who they provided support to. The provider was set to support people with a learning disability, however we found older people living with dementia and people with complex mental health needs also lived in the home which was not in-line with the provider's statement of purpose.

There was a registered manager working at the home at the time of our inspection. 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 2008 and associated Regulations about how the service is run.

Where risks to people's health were identified people had not been adequately assessed or reviewed to understand if the support in place was adequate. The guidance given to staff was not based on best practice nor had the registered manager sought help from external healthcare professionals to ensure the right support was being offered. This put people at potential harm of unsafe care and treatment. There were not sufficient staffing levels in place to keep people safe from harm and to support people safely in the community. People's medication was managed in a safe way; however checks and reviews of people's medicines were inconsistent.

People had not had proper assessments of their care. People, their relatives and professionals had not been involved in the planning of the care to ensure this was consistently being delivered in the right way. The registered manager had not followed the principles of The Mental Capacity Act 2005 (MCA) and could not demonstrate that care and support was being offered in people's best interests. The registered manager did not recognise when they were restricting people and had not understood the role and responsibilities in accordance with this. The registered manager had not made any Deprivation of Liberty Safeguards (DoLS) application to the Local Authority to ensure the care was being provided in a legalised way.

Staff received online training. The provider had plans in place to check staff's competence and understanding, however these had not been implemented at the time of our inspection. Staff had not always received training that was specific to people's care needs. We found people continued not to be supported to eat a healthy balanced diet. Some people had diagnoses of obesity and the provider could not demonstrate how they had adequately support people, particularly given that we had identified this as an area of concern at our last inspection. We found that people had access to healthcare professionals when they became unwell or had an accident; however we found people were not supported to access healthcare services for on-going physical and mental health conditions.

Staff completed all tasks within the home which took them away from their caring role. People were not

always supported to go on outings as there were insufficient staff to always support them. People's care and support was not always delivered in a respectful way and we identified areas which compromised people's dignity.

People did not always receive care that was responsive to their individual needs and people continued to not be supported to maintain their interests and hobbies. Information on how to raise complaints was provided to people in an easy read format, and people and relatives knew how to make a complaint if they needed to.

People and staff felt the registered manager was supportive. There continued to be ineffective systems in place to ensure the service was delivering good quality care. The provider did not understand their responsibilities in ensuring they were meeting the legal requirements and did not have a robust systems in place to identify areas for improvement. The providers had not been able to assure themselves their staff team were delivering good quality care to people.

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.

People's risks had been identified however these were not always well managed which put people at risk of potential harm. Staff had an understanding of safeguarding and how to report abuse. Staffing levels did not reflect people's individual needs. People received their medicines in a safe way.

Is the service effective?

Inadequate

The service was not effective.

People were not always encouraged to have healthy food to promote their health and wellbeing. People were being restricted of their freedom without the correct authorisations in place. Where people lacked capacity to make decisions about their care and treatment this was not always done following the MCA principles. People did not always have access to appropriate external healthcare professionals for their health conditions. We did see that when people became ill or had an accident external healthcare support was sought.

Is the service caring?

Requires Improvement

The service was not caring.

Staff did not always have time to spend with them and were task focused in their approach. People were mostly spoken to in a friendly and kind way.

Is the service responsive?

Requires Improvement

The service was not responsive.

People continued to not receive care that was in-line with their individual needs. People continued to not be supported with activities that they enjoyed.
People and relatives had access to a complaints policy which was available in an easy read format.

Is the service well-led?

Inadequate

The service was not well-led.

There were no systems and checks in place to ensure people were receiving a good quality service. The provider had not recognised that improvements were needed and had not taken any steps to address this. The lack of checks put people at risk of unsafe care and treatment and potential risk of harm.

Ormidale House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We undertook an unannounced comprehensive inspection on 15 and 19 March 2017. One the first day the inspection team consisted of one inspector and one inspection manager. On the second day the inspection team consisted of two inspectors and a specialist advisor who was a learning disabilities specialist.

Prior to our inspection we had received information of concern from a staff member. We also spoke with the local authority about information they held about the provider. Due to the concerns we brought forward the inspection of this service to understand if people were receiving good quality care and to understand if the provider was now meeting the breaches of regulation we identified in June 2017.

As part of the inspection we reviewed information we held about the service including, statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

Some people we spoke with were not able to tell us in detail about their care and support because of their complex needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who used the service, one relative and received written information from a further relative. We also spoke with six care staff, the registered manager and the provider.

We reviewed aspects of seven people's care records, medication records and daily records. We also looked at the staff rota, staff meeting minutes, three recruitment files, the complaints policy and procedure and aspects of staff's training records.

Inadequate

Is the service safe?

Our findings

At the last inspection in June 2017 we rated this key question as Requires Improvement and gave the provider a breach of Regulation 15 Premises and Equipment, this was because the provider had not ensured the premises were safe and free from hazards. At this inspection, we found the key question had declined to Inadequate.

Prior to our inspection we received concerns from an anonymous whistle blower. A whistle blower is a member of staff who works at the service who has raised concerns about aspects of people's care to an external agency. The concerns they had raised were allegations of physical and emotional abuse. We immediately shared these concerns with the local authority, who are responsible for investigating allegations of abuse and involving other agencies, such as the police, where deemed necessary. We have continued to share information with the local authority during this time, to ensure people were safe in the home.

We visited the home and spoke with people to understand if they felt safe from harm. All people we spoke with told us they felt safe. One person told us, "Nice staff who visit me". While a further person told us, "I know all the staff and I like them all". People told us they felt safe when in the communal rooms and their own bedrooms. People did not express to us any reason for them to feel unsafe from the staff. We spent time in the communal areas of the home to understand how people responded to the staff who supported them. We found that people were comfortable in staff's presence. People spoke to staff in a relaxed way and looked settled in their home. We saw people who could mobilise within the home, for example, if people wished to go to their room they did this without asking staff.

All the staff who we spoke with showed an awareness of how they would protect people from abuse. They shared examples of what they would report to management or external agencies if required. However through reviewing people's care records and through discussions with staff, it showed that staff did not have clear guidance or understanding of the difference between informed positive risk taking, to uninformed risk taking. The provider had not assessed people's understanding into certain decisions they would need to make to assure themselves people were making an informed choice where they understood the risks they were taking. We found that while people were taking risks, the provider could not be assured that this was always done in a safe way.

People did not share with us how they were supported by staff to be involved in their care planning. We spoke with the registered manager about the people who lived in the home and their individual care and support needs. The registered manager knew people well, they were knowledgeable about people's lives before they moved into the home and what support staff were offering people while living in the home. We looked at aspects of peoples care records to understand how the registered manager had assessed people's risks. From the care records we read that the risk assessments did not show people, their advocate or other healthcare professionals had been actively involved in their care planning to ensure people were being protected and supported in the best way.

The registered manager had identified that female staff may be at potential risk of sexual harm from a person who lived in the home and had put measures in place to protect the staff. However we found that the registered manager had not assessed the potential risk to people who lived in the home and had not put any robust measures in place to mitigate potential risk. The registered manager had not put adequate steps in place to ensure those who were in a relationship had the right guidance and support around staying safe and adequately protecting themselves from risk of sexually transmitted infections. Due to this, we could not be sure some people were always safe from harm. We informed the registered manager that we were making a safeguarding referral to the local authority, so that full assessments could be carried out to ensure people were being kept safe. We spoke with the local authority following their investigation. The local authority advised that they felt the people involved were being kept safe from harm and no further action was required.

We found other examples where lack of assessments put people at risk of harm. For example, where staff and care records described some people as having challenging behaviour, advice and input from external healthcare professionals had not been sought to assist staff in supporting people in the right way. There were no behaviour management plans in place. The advice had been written by the registered manager, which told the staff to contact them if a person displayed challenging behaviour. We spoke with staff to understand what they would do. Staff confirmed they would contact the registered manager if they could not manage a person's challenging behaviour. However, this is not best practice as the registered manager could not always be readily available to support people or offer guidance to staff. Healthcare professionals had not been involved to ensure people received the correct support by staff who were competent to do so. This left people open to potentially inappropriate and unsafe support given by staff who did not have the skills and proper guidance to support people if they displayed challenging behaviour.

The provider had failed to ensure that staff were knowledgeable of people's identified risk of choking. Records we looked at during our inspection showed two people had a high risk of choking, with the registered manager confirming that back slaps had been given to one person in the past. The registered manager had failed to refer both people to their doctors for a swallowing assessment. The two people remained at risk of choking as staff provided them with foods that are deemed high risk of choking, such as toast. Staff told us they had not done practical training for basic life support. Staff had not received adequate training in basic life support to enable them to respond to emergencies such as choking. Staff did not have clear guidance about how they could reduce the risks to the two people and ensure their safety.

All of the above information demonstrates there was a breach in regulation which was Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe Care and Treatment.

People who we spoke with did not raise a concern about the staffing levels in the home. Staff we spoke with felt they worked well together as a team to meet people's daily care needs. We spoke with the registered manager around people's individual needs to see how they determined the correct staffing levels. They told us there was always three care staff during the day and two care staff at night. They told us staffing levels were based on what they had always had and not dependant on people's individual care needs. The registered manager told us that staff completed all tasks within the home, from cooking, to laundry and domestic duties which took staff away from their caring role. We saw that where some people wanted to do things, such as go outside, staff would advise them that there were insufficient staff to support them. The service was run to the staffs demands and not to the people who required the support. The registered manager told us this had resulted in them working additional shifts and when they could not do this the staffing levels did not always reach the providers expected levels of staff to be working.

People received restrictive care because of the low staffing levels. People's care records showed how many

staff were required to support people with their personal care and while out in the community. The registered manager agreed that the current staffing levels were not reflective of people's actual care needs. There were some people who required one to one support while out in the community to keep them safe, for example, with road safety, the registered manager told us that people did not always go out as there were not enough staff to support people. They told us and we saw that people could not always go out if they wished. For example, over the two days of our inspection we saw two people repeatedly ask staff if they could go outside. We saw this did not always happen for one person as there were not always enough staff available to assist the person outside. We saw this person would stamp their foot when staff told them they had to wait. We found further examples were people's needs and preferences were not met. For example, in one person's care record we read that they would like and benefit from evening walks with staff to help aid their sleep. We saw from their records and staff confirmed they were not offer this choice and the person remained in their bedroom during the evening. Staff described times where the person would be up during the night time and unable to settle.

All of the above information demonstrates there was a breach in regulation which was Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Staffing.

People we spoke with felt their medicines were given in a safe way. We watched how a staff member supported people to take their medicines safely as prescribed. They showed good awareness of safe practices when handling and administering medicines and a good understanding about the medicines they gave people and the possible side effects. We found people's medicines was stored and managed in a way that kept people safe.

We checked the recruitment files for three of the care staff who worked there. We found that the provider was carrying out the right checks to ensure they were employing staff who were safe and fit to do so.

People and relatives did not raise any concerns about the cleanliness of the home. Staff told us they completed the domestic tasks within the home. However we observed some areas of poor infection control practice. For example, we saw some staff with long and painted finger nails, which would not only place people at risk of cross infection but also potential injury. We saw that people shared a communal laundry bin, which again increased the risk of cross infection. We did find areas within the kitchen area where best practice was not followed. For example, when food had been opened from its original packaging it had not been dated to ensure it was still within date. The provider did not evidence that infection control checks were being carried out to identify these shortfalls so they could be addressed promptly.

The provider could not evidence what learning and changes had taken place since our last inspection. The registered manager told us that there were plans to put checks in place so that learning from these could then take place, however these had not happened at the time of the inspection. We found that were an action had been identified to improve the safety of the home this had not been taken. For example, it had been identified that a gate was needed to secure the garden to keep some people safe who were not aware of road safety. The gate had not been installed when the registered manager told us it would be. They told us this had been due to the weather as they were installing the gate themselves and was working within the home. There were no further dates or plans to demonstrate this was being treated as a priority. This meant that the provider was unable to demonstrate they were responding to concerns where these had been identified.

Inadequate

Is the service effective?

Our findings

At the last inspection we rated this key question as requires improvement. This was because people were not always supported with their diet to ensure their weight did not affect their health. At this inspection we have rated this key question as Inadequate.

At our last inspection visit we identified that people were not always supported with their weight management. We found this issue continued and people remained unsupported with their diet. For example, people's weight was not monitored on a regular basis to minimise any risk of malnutrition, obesity or ill health. Three people living in the home had a diagnosis of obesity, and records shown only one person had received input from a dietician. The Registered Manager confirmed that the three other people had not been referred to their doctor for assessment and specialist input. We found that these people's weights had not been completed every week in line with the guidance in their care plans. We found that some people had not had their weight monitored in some cases for six months. We spoke with one staff member who told us people were weighed, however they would forget to record this. We found for one person their health had declined and had resulted in a further diagnosis which required additional medicine and regular monitoring. This showed that the provider had not adequately supported people with their health conditions and as a result their health was deteriorating.

There was no evidence to demonstrate that people had been involved in the planning of their care to enable them to make informed choices about the food they ate. From reading people's daily records we could see that people ate high sugar and high calorie diets. On the day of inspection we saw people were offered biscuits as snacks, or supported to the shops to buy sweets and chocolates. However we did not see any offerings of healthy food, such as fruit, through-out the two days of our inspection. The daily records that we reviewed only described people as eating chocolate and biscuits with no offering of alternative healthy option. We found people were not provided with information about making healthy choices.

The service provides support to people who have varied and complex health care needs. People we met had lived in the home for many years. However, when we looked at seven people's care records we could see that each person's care had not been fully assessed or regularly reviewed. For example, we found that people's medicines were not regularly reviewed to ensure they were on the right medicine that was working effectively for the person. One person had diagnoses of epilepsy and was receiving medication for this. The registered manager told us the person had a certain type of seizure regularly. However the person's care records did not demonstrate that the seizures were monitored or reviewed by an external healthcare professional. The registered manager felt certain diagnoses were not accurate but they had not sought external professional advice for a proper assessment to ensure people were receiving the right support and treatment. This meant the provider could not be assured that people were always receiving the right care and support with their care needs. People had not always received referrals to external healthcare professionals, which had resulted in people not always receiving the care and support that was in line with best practice.

All of the above information demonstrates there was a breach in regulation which was Regulation 12 of the

Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe Care and Treatment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager lacked the understanding of the MCA principles. They discussed with us people who lacked capacity to make certain decisions around aspects of their care, but had not taken further action to address this. We saw and read examples were care and support that was being provided without an assessment to understand if people had the capacity to consent to it. The registered manager promoted choice to people, however had not considered that the choices people made were fully understood. For example, three people living in the home had been diagnosed as obese. The daily records for one person showed they regularly ate high sugar and high calorie foods. We spoke with one relative who discussed their family member's weight and their concern for their health because of this. Staff told us the person made their own food independently, however staff had not considered whether the person understood the food choices they were making could be detrimental to their health. There were no capacity assessments to establish if people's choice of foods was done with the understanding of the risk of these food choices.

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.

People, their family members, advocates or healthcare professionals had not been involved in their care planning to show that care was being provided in the person's best interests. Where the staff had recognised people were being restricted, the registered manager had not made any DoLS referrals to be sure this was being done in a legalised way.

Where staff had identified people lacked capacity to make specific decisions about their care and support, the provider had failed to ensure they had followed the principles of the Mental Capacity Act 2005. For example, staff told us two people who lived in the home lacked the capacity to understand road safety. Staff told us to keep them safe from harm they kept them inside the home and they were only supported to go outside with a staff member. While we understand that staff were keeping people safe from harm, the registered manager had not recognised this restriction on people's movements as a potential deprivation of their liberty. There had been no referral for Deprivation of Liberty Safeguards for the two people we saw.

All of the above information demonstrates there was a breach in regulation which was Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.The need for consent.

We asked people if they felt staff looked after them well. One person told us, "Yes, their alright". Staff we spoke with told us their training had been completed online, which covered areas of training the provider considered essential such as safeguarding and moving and handling. Staff told us they felt the training was sufficient for them in their role. On the first day of our inspection visit all care staff were receiving human rights training. We spoke with some staff following this who told us this had been useful, however could not demonstrate how they would effectively put this into practice with the way they supported people.

We spoke with the registered manager to understand if staff had training in specific care areas to support

people's individual needs as people who lived at the home had a wide range of varying care needs. We discussed with the registered manager specific training for people with individual care needs, for example stoma care. They told us this had been received years ago, and the care staff had changed since this time. They told us they had provided the training to new staff, however, the registered manager had not refreshed their knowledge to ensure they were training the staff in line with best practice. The registered manager told us that staff were not completing the Care Certificate, and would only do this when it became mandatory. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of those who work in Health and Social Care. Staff told us that all training was done online with only practical training for assisting people to move with the use of a hoist. We found other examples where staff supported people without any training, such as dementia care. We saw people who had a dementia diagnoses, and found that staff lacked the knowledge to support people in the right way.

We spoke with the registered manager about competency checks of the staff to ensure they had the right skills and knowledge. They told us that competency checks and spot checks were something that required further work. They told us that previously spot checks would be done but only followed up with the staff member at their annual appraisal. They told us that this had not been the best approach for improving practice, and was looking to implement supervisions and spot checks and address these with staff in a more timely manner. However, the registered manager had not done any of the checks to show us how this would or had improved staff practice and performance. As people living in the home had a wide range of complex care needs, the provider could not be assured that the staff they had employed where fully trained in all aspects of the care they delivered and were competent in this.

All of the above information demonstrates there was an addition to breach in regulation which was Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.The need for Staffing.

We spent time in the communal area during lunch time to understand people's experiences. We found this to be a poor experience for people. We asked one person if they had enjoyed their meal and they nodded their head. We saw one person who had remained in their wheelchair since we arrived at the home in the morning. A staff member turned the person around to face the table without communicating to them. The table was not laid with condiments or napkins to represent a lunch time meal. Staff provided people with a choice of a sandwich or egg on toast. We saw people ate this with limited conversation from staff. Staff did not offer people any further food once they had finished. The weekly menu was on a large white board in the dining room area. This was not in a format that would benefit people living in the home. We saw the choices were limited, and records we looked at did not demonstrate that people or their relatives where appropriate had been involved in developing meals that people liked and enjoyed.

We saw people were supported with drinks throughout the day. Staff advised there was no person at risk of dehydration and people were able to request more drinks if they wished.

People we spoke with were unable to confirm if they had visited the doctor regularly. People did tell us that when they became unwell staff had called the ambulance so they could go to hospital. A further person told us of a time they became unwell and staff rang for the doctor and they had an operation. A relative we spoke with told us their family member could visit the doctor if they had needed to for an illness that they may have. People's care records showed that people did not have regular input from external healthcare agencies. People did not receive regular and relevant input in relation to their diagnosed health conditions to ensure their needs were being met.

At our last inspection we found concerns with the environment that people lived in. We found that while

some of the work had taken place, such as the disused building in the garden with broken window panes causing a risk of injury had been removed. It was clear the provider had not invested in the home to provide an environment which was suitable or beneficial for people with learning disabilities and/or dementia. The registered manager had asked the provider for a sensory room. The room was now called the quiet lounge as it did not benefit a person who required sensory input. The quiet lounge had no heating and we found this to be cold. The registered manager told us people did not use this. The registered manager told us there were no other plans to make a sensory room for people. The lounge had sofa's which had collapsed on the seating area and smelt of stale urine. People's bedrooms were tired, with curtains hanging off the rails and old heating systems taped up so people could not press the buttons. A staff member said the sofas were being replaced, however the provider did not engage with us to demonstrate what plans they were taking to improve the environment for people.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in June 2017 we rated this key question as Good. However at this inspection we have given the provider a rating of Requires Improvement.

We saw staff were kind towards people however were limited by what they could offer people due to the low staffing levels. Staff were task focused in their approach to providing support for people. We saw the care staff and the registered manager completed all tasks in the home. For example, they would make all of the meals, do the laundry, the cleaning and aspects of the maintenance. We saw that these tasks took care staff away from their caring role.

This not only impacted people's daily lives but also on the staff being able to plan future events such as going on day trips. The registered manager told us they did not have a big enough staff group to enable them to arrange extra shifts to support people on activities. For example, one person had been invited to a birthday party on the Sunday. The registered manager told us they were trying to get enough staff on duty to be able to support the person to the party. They told us it was times like this that they felt they let people down as people were restricted to live their lives to the fullest due to the service provision.

People's right to be treated with dignity and respect was sometimes appreciated by the staff we spoke with. We heard staff speaking with people in a calm and quite manner. Where people required assistance to use the bathroom, this was done in a respectful and dignified way. However we heard a staff member who was completing daily records in the lounge shout across the room to people to ask them what they had eaten for lunch. We saw people who lived with dementia or had a learning disability were confused by this estranged voice and would not always understand the question.

People were not encouraged to maintain their independence and make their own day to day decisions. People were not part of the running of the home to enable them to feel valued. Staff could not show us how they supported people to increase their independence for example, through developing skills to equip them with a more independent way of living. We saw some people's bedrooms were decorated with items and possessions that they liked. However in some people's bedrooms we saw curtains hanging off the rails and dirty rugs on the floor. There was a lack of understanding from staff as to how support people with their life choices, cultural and religious beliefs. One person told us they would wish to visit their family member's grave however had not been able to discuss this with staff to arrange this. One person who lived in the home had not been offered or supported to visit their partner in hospital. Staff told us that they would update the person but noticed a decline in their mental well-being during this time of not seeing their partner.

All of the above information demonstrates there was a breach in regulation which was Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Dignity and Respect.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in June 2017 we rated this key question as Requires Improvement. This was because there was a lack of activities for people to engage in. At this inspection we found the key question continued to be Requires Improvement.

The provider had continued to be unresponsive in meeting people's social care needs. We found that through lack of proper planning of recruitment of more staff and the deployment and staffing levels of the existing staff people's care needs were not fully meet in line with their preferences. One relative felt their family member was isolated from society as they were unable to do the things they enjoyed, such as going to the cinema or going to the bingo. From daily records we viewed for people we could see each day was the same as the previous day, with no variation or events to look forward too. We saw people were at times withdrawn and holding their heads in their hands, they spoke to staff when spoken to, but did not always openly engage with staff.

One staff member told us that people did not have access to a car to enable staff to take them to different places. Staff said that public transport was not always suitable for some people as they would become anxious. The registered manager told us that people would greatly benefit from visiting different places and gaining the freedom to do so. People did not comment to us about their ability to do something different on the weekend or evenings when they were not at various day centres. Staff told us that they would bake cakes with some people in the kitchen on the weekend or dance with them. From the care records we reviewed we saw that very little activity happened during the evenings and weekends. There were no future plans for people, trips or events for people to look forward to. The registered manager told us that two people used to enjoy going on holiday but mostly went to the same place. However through speaking with people and their relatives they told us they were "fed up" of going to the same place for a holiday, the registered manager confirmed this was probably true. This demonstrates that people were not always offered alternative choices of where they would like to go on holiday.

Staff told us that as some of the people living in the home were getting older and they did not want to go out as much. However we could not see how staff had encouraged people to venture out or provide a varied assortment of activities that were in line with people's interests. We spoke with one person who spoke to us about the old films they used to enjoy watching before moving into the home. They told us that now they watched various types of reality television programmes. We asked them if they enjoyed watching these types of programmes, they told us they, "Didn't mind" but, "preferred the old films". During the afternoon on our second day a staff member asked people what would they like on the television. All people showed no interest in the television, except for one person who asked to watch the football. However this request was not acknowledged and a radio channel was put on, this showed that staff were not listening to the person's wishes.

Two people who lived in the home enjoyed painting and their impressive art work was displayed on the walls. We met one of these people in the lounge area and saw they were sat next to a library of books. The registered manager told us they enjoyed reading their books that they had brought from home when they

had first moved in. However the person had lived there for many years and staff and the registered manager told us that the person did not visit a library or have a mobile library come to the home, to give the person the opportunity to read something else. We then asked staff if the person was supported to continue painting in the style they preferred. Staff showed us a children's colouring book and said the person had some colouring pens, but confirmed the person did not use the colouring book. Staff could not be clear why the person only had access to a children's colouring book and why the person's hobby had infantilised.

All of the above information demonstrates there was a continued breach in regulation which was Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Person Centred Care.

One person we spoke with told us they went to the day centre regularly and enjoyed this. Three other people we spoke with did not express a desire to go outside and told us they were happy to stay indoors. On the second day of our visit a staff member had set up skittles for people to play. We saw some people joined in with this game, which they looked to enjoy.

People had lived in the home for many years and so the registered manager knew people and their past lives well. People and relatives we spoke with confirmed they knew the registered manager and found them to be supportive. We asked people if they were happy with the support they received. People we spoke with did not express much of an opinion to us about this, with one person saying about the supported offered to them was "Alright". We looked at care records to understand how staff were reviewing people's care needs to see if they were responding to any changes. We saw staff did not monitor people's changing care needs and were only reactive to people ill health. We saw that where people's diagnoses had declined, the staff were not proactive in ensuring people had the best possible outcomes. There were no clear systems in place for the provider to be assured that people living throughout the home were consistently receiving responsive care that met their individual needs.

People and relatives knew who they could speak to if they had any concerns. People we spoke with told us they had not raised a complaint about the service in the past. One relative we spoke with told us they felt confident to speak with the registered manager where required. They told us that any concerns they had previously the registered manager had listened to them. We saw that a complaints procedure was available in an easy read format. An easy read complaints procedure is produced in different formats for example large print, or with some text represented by pictures or symbols to ensure that it is easier to read. No complaints had been made by people or their relatives.

Inadequate

Is the service well-led?

Our findings

At the last inspection in June 2017 we rated this key question as Requires Improvement and gave the provider a breach of Regulation 17 Good Governance, this was because quality audits and monitoring had failed to identify that people were at risk from unsafe premises. At this inspection, we found the key question had declined to Inadequate, this was because the provider had continued not assess, improve or mitigate risk to people. We have identified multiple breaches of regulation which has meant people have received poor care and support.

The provider and registered manager confirmed they were unclear of what the previous breaches were following the last inspection. The provider recalled one was around the premises being unsafe and then said, "I don't know, there was quite a lot of writing in the report". We advised the provider the concerns were around the provider's lack of oversight of the running of their service.

The provider told us they now completed checks on the registered manager's paperwork, but were unable to show us what these checks looked like, how they put this into practice, or what changes and outcomes this had meant for people. The provider told us they did not have a health and social care background to test the registered manager's knowledge and work themselves. Given the providers openness around their lack of knowledge we asked the provider if they had sought any external assistance to help them monitor the quality of the service. The provider confirmed they had not considered this as an option. This had meant the provider continued to not have robust checks in place to ensure the registered manager was taking the necessary action. There were no formal plans to identify the work required and prioritise this. This showed that the provider had failed to take steps to assure themselves or to support the registered manager that the service was delivering good quality care.

The lack of monitoring had meant that the provider had not made all of the necessary improvements to the service which had been highlighted by CQC at the last inspection. We found that our concerns identified at the last inspection had not fully been addressed, such as effective monitoring of people's weight, low staffing levels which had impacted on people social support. We could not see that any improvements around these areas had been made and the quality of the service had declined further. The registered manager told us that they had no support from systems or professionals to improve the service for people. The registered manager told us that they often worked in isolation, assessing individuals and planning care without the involvement of healthcare professionals. While the registered manager told us they had made attempts to seek support they were unable to evidence that referrals and reviews, for example, for dietician input had always been requested.

The provider could not demonstrate they had spoken with people, their relatives and advocates to understand if the service provision was meeting people's needs. Where there had been changes made to the environment, the provider could not evidence this was in line with people's involvement and their wishes. We saw the provider had held a meeting for staff they had used this opportunity to address some areas of concern they had identified, such as inappropriate conversations in the presence of people, which they told us did not happen anymore. However we found the provider had not used this opportunity to listen to the

staff about their ideas to improve the service. Some staff told us they would like to see improvements around the environment for people, particularly for the communal areas needing to be more homely. We saw the communal areas had large whiteboards and notice boards, which did not promote a homely environment for people.

The registered manager could not demonstrate they had checks in place to assure themselves that staff were supporting people in the right way. There was no clear system to report or review serious incidents including choking, falls, injury to people or staff, medication errors, verbal or physical abuse including near misses. This meant for example, where a person was having seizure incidents there was no review or assessment that took place to ensure the person continued to receive the right care and treatment. The lack of monitoring systems meant that the provider could not identify potential shortfalls in staff's knowledge and understanding, to develop this through refresher training and additional competency checks. With no systems to highlight and address incidents the provider was putting people at risk of potential harm that could have been avoided.

The registered manager told us that since January 2018 they were being supported by the local authority to put in place better monitoring and quality audits. However, we could not see that the registered manager had begun to implement this support. The registered manager and staff told us it had not been implemented and would begin in six weeks' time when the staff had been trained and appointed to an individual person. However these shortfalls had been discussed with the registered manager at the last inspection, and they had continued to fail to put robust systems in place that could identify errors, mistake or omissions. This would have allowed a time for staff to learn from errors and mistakes to improve safety and care.

The provider did not have systems in place to ensure the environment was clean and hygienic and as a result we saw people were at risk of cross infection. The examples we saw of poor hygiene of the home and unkempt bedrooms had not been addressed by the provider, we could not see that staff had also raised this as a concern or taken action to address this. This demonstrates that the provider did not always lead by example in developing the culture of the staff to promote the development of an honest, open, transparent and just culture within the home.

The providers systems had not identified that records held were not accurate, dated, contemporaneous or stored appropriately. Records for people's capacity around finance and some of people's past history that were still relevant had been archived and were unavailable. We found that care plans and risk assessments were not dated to demonstrate when they had been written.

All of the above information demonstrates there was a breach in regulation which was Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

People we spoke with told us they felt happy with the way the service was run. Relatives also told us they felt overall happy with the way the service was run, however did comment that some improvements were required around providing opportunities for activities for people along with improving the communal areas for people to provide more stimulation. Staff we spoke with felt supported by the registered manager and felt they did their best to provide people with a good service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA were not followed. People had not been involved in decisions around their care. The provider was not ensuring the support offered was in line with their best interests. Where people were being restricted the registered manager had not recognised their responsibilities to ensure this was being done in a legalised way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff on duty to support people in the home and out in the community.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care needs assessed and reviewed and did not always reflect people's preferences.

The enforcement action we took:

We have imposed a condition for the provider to address this breach and update us monthly with their progress

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The environment people lived in did not always promote their dignity.

The enforcement action we took:

We have imposed a condition for the provider to address this breach and update us monthly with their progress

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Identified risks were not always supported by external healthcare professional support and guidance. The plans in place where not in line with best practice. People were put at risk of harm through inadequate support systems

The enforcement action we took:

We have imposed a condition for the provider to address this breach and update us monthly with their progress

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance here were no systems and checks in place to ensure people were receiving a good quality service. The provider had not recognised that

improvements were needed and had not taken any steps to address this. The lack of checks put people at risk of unsafe care and treatment and potential risk of harm.

The enforcement action we took:

We have imposed a condition for the provider to address this breach and update us monthly with their progress