Matthew & Michael Healthcare Ltd

Stepping Stones

Inspection report

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Date of inspection visit:
15 March 2018
20 March 2018

Date of publication:
27 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 15 and 20 March 2018.

Stepping Stones 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 care home provides accommodation and personal care for up to 15 younger adults who have a learning and/or physical disability. The care home is located on one site, but split across two care homes (Bungalows) both accommodating six people, as well as three individual flats. On the day of the inspection 15 people were living at the service.

The service had a registered manager however they had not been working since September 2017. In their absence, the provider had put an acting manager in charge of the day to day running of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person's'. 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. However, in line with their provider's legal obligations, they had failed to inform the Commission of the registered manager's long term absence. Following our inspection the provider apologised and promptly submitted the relevant notification. They told us they now understood the process and would ensure this did not happen again.

During our discussions with people, they provided hesitant and apologetic responses to questions asked about the service, and one person told us they did not always feel confident to raise concerns, therefore we made a safeguarding alert to the local authority adult safeguarding team, to ensure people were fully protected.

Overall, risks associated with people's care had been documented to help ensure people's needs were known and met safely by staff. However, risks associated with one person's care had recently changed and whilst a new risk plan had been put into place, it was not being correctly followed by staff. This meant the person was at risk of receiving inconsistent care that did not meet their current needs.

People told us there were not always enough staff to meet their needs. Comments included, "They need more staff, there aren't enough", and "If I call in the morning when handover is going on I am told to wait". Relatives told us they did not feel there was enough staff to ensure people were supported with independent living skills, and to promote and deliver opportunities for social engagement. Staff also told us they were unable to effectively promote people's independence, because they did not feel there was enough staff. They told us, "We could do a whole lot more, if we had more staff" and "There aren't enough of us".

Overall, people received their medicines safely. A medicine audit was in place to help monitor medicine practices and identify where improvements were required, however this had not been carried out since September 2017, therefore had not identified current issues requiring attention.

People were assisted with their mobility, by the use of moving and handling equipment, such as hoists. To ensure people's safety, staff had received training. However, one person told us their sling for the hoist cut into their groin and it hurt, they told us staff, were looking into this. However, when we told the acting manager they had not been made aware and the sling was still being used.

People lived in a service whereby the temperature was not monitored to ensure it met with people's preferences. Whilst people did not complain to us or staff, during our inspection communal areas and bedrooms were not always warm. One relative told us they had also complained about the temperature of the service but no action had been taken to monitor temperatures.

Staff had undertaken training the provider had deemed as 'mandatory'. However, training specific to people's needs had not been completed. For example, staff had not been trained to support people with physical or learning disabilities. People living with complex communication needs, relied on staff 'getting to know' them, rather than staff undertaking relevant training. New staff joining the service received an induction to help introduce them to the provider's policy and procedures. Staff meetings had recently started to take place, but regular one to one supervision of staff practice and appraisals of performance had lapsed. Despite this, staff told us they felt supported.

People were not always empowered by the design, adaptation and decoration of the service. The environment was tired. Door frames and walls were scuffed, paint was peeling off walls and a lock on a bathroom did not work. Lounge areas did not always have sofas or chairs for people to sit on, if they chose to not be in their wheelchair. The provider told us, there was a refurbishment plan in place, with two new kitchens being fitted in the summer. Some bedrooms had also been re-decorated and radiators replaced.

People were supported to have a balanced diet, and live a healthy life. People were encouraged to eat fresh fruit and vegetables and had independent access to drinks and snacks. People helped with the preparation of meals, such as peeling and chopping vegetables. However, the menu was typed, which did not take into consideration people's individual communication needs.

People were not always respected and supported by compassionate staff. There was limited fun and uplifting conversation between people and staff, and on four occasions during our inspection people were ignored by staff as they walked through the lounge. Staff, were observed to be focused on completing tasks, such as washing and cleaning, rather than engaging with people.

The provider's philosophy was based on empowering people to become independent to enable then to move from residential care to living independently, however people's support plans did not detail how people could achieve this and gain confidence and skills, and staff told us they did not always have time to spend with people to enable this to happen.

People were involved in decisions relating to their health and social wellbeing, but one relative told us they were not always kept updated when their loved one had attended healthcare appointments.

People's bedrooms were individually personalised, and their families and friends were welcome to visit at any time. People's support plans provided good detail about how people wanted their privacy and dignity to be maintained, but staff did not always knock on people's bedroom doors, prior to entering.

People told us there was not enough to do, and that they sometimes felt bored. Comments included, "There are not enough activities, I want to go out more, go to the cinema…do some cooking", "I don't want to sit around and be bored all the time" and "I want more things to do". Relatives also told us they did not feel there was enough socially for people to do.

People had support plans in place, which were detailed about how their needs should be met. Support plans were reviewed annually, or as required. Relatives told us they had not always been involved in the review of their loved ones support plan, to help ensure it met with their needs and wishes. People's support plans did not detail what their aims and goals were for now and for the future. This meant people did not have a focus to be motivated by. People's cultural and spiritual needs were not documented to enable them to be known, and therefore met.

One relative told us they did not feel that people's personal care was always managed effectively, and told us when they arrived sometimes their loved one looked dishevelled. Commenting, "They need more help with their personal care, it all depends who gets [person's name] up".

Overall, people's concerns and complaints were listened to and used to help improve the service. However, one relative told us how they had made small comments about things which needed addressing, however no action had been taken, so they had to make a formal complaint. People had received a copy of the complaints procedure however it was only available in a written format, which meant it may not have been suitable for everyone to understand.

The provider had met with people and staff to inform them about the interim management arrangements. Overall, people, staff and relatives told us the acting manager had the skills to manage the service. The acting manager told us, they felt well supported by the provider who visited most months, and was available by phone on a daily basis.

People lived in a service, which was not effectively assessed or monitored by the provider, to ensure its ongoing safety and quality, because the provider was not aware of their responsibilities.
There were some quality checks in place, however these had not been completed since the absence of the registered manager. People's confidential information was not always kept securely in line with the Data Protection Act 1995.

People lived in an environment which did not always have a positive and inclusive culture. The atmosphere within the service was based on the completion of tasks, rather than focusing on people. The provider's ethos of promoting people's independence was not embedded into staff practice. Leadership, direction and positive role modelling within the service was absent, which resulted in people not always being empowered and motivated to live fulfilled lives.

People did not live in a service where there was continuous learning taking place to help facilitate improvement. The provider or staff did not attend any other forums or conferences, to help discuss best practice with regard to how to support people effectively and to help ensure the ongoing and sustainably of the service.

However, people told us they felt safe living at the service. Relatives told us they were also confident about the overall safety of their loved one. People were protected from abuse because staff had received safeguarding training and knew what action to take, if they were concerned someone was being abused, mistreated or neglected. Staff, were recruited safely, and the required checks carried out such as with the disclosure and barring service (DBS). This ensured they were suitable to work with vulnerable adults.

People were supported to manage their finances. Individual records were kept detailing people's financial transactions, and when people needed specific support to manage their finances, they had support plans in place which they had agreed to.

People lived in an environment which was safe. Fire checks were carried out and people had personal emergency evacuations plans (PEEPs) in place. PEEPs help to provide information to emergency service about how people should be supported in an emergency.

People were protected from infection control practices. Staff had received training in infection control, and put their knowledge into practice. The kitchens had been awarded five stars by the Environmental Health (EH), the highest rating available.

People's health and social care needs were effectively managed and co-ordinated. People's care records detailed how external health and social care professionals were involved in their ongoing care.

People's human rights were protected in line with the Mental Capacity Act (MCA) 2005, the acting manager and staff had a basic understanding of the legislative framework.

People, staff and the public were involved in the ongoing development of the service. The provider had met with people and staff recently to discuss the service, and had taken action in response to people's feedback.

The provider and acting manager learnt when things went wrong and worked in partnership with external agencies in an open and transparent way, for the benefit of people. For example, the acting manager had worked positively with the local authority following a recent safeguarding alert, to help facilitate improvement.

We found four breaches of our regulations during this inspection. We recommend the provider monitor's the temperature of the environment in line with the guidance set out by the Health and Safety Executive (HSE), and uses a staffing tool to help ensure staffing levels are suitable to meet people's needs. In addition, we recommend the provider takes account of the Accessible Information Standard (AIS) and uses it to help improve the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

Risks associated with people's care were managed safely. However, up to date guidance was not always in place for staff to follow.

Overall, people received their medicines safely. However, monitoring systems were not always robust at identifying when improvements were required.

People told us there were not always enough staff to meet their needs.

People told us they felt safe. People were protected from abuse.

People were protected by infection control practices.

Lessons were learnt, when things went wrong.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

People were supported by staff who had not received training to be able to meet their needs effectively.

People were not always empowered by the design, adaptation and decoration of the service.

People's individual communication needs were known by staff but communication methods to share information were not always in line with how people communicated.

People were supported to have a balanced diet, and live a healthy life.

People's health and social care needs were effectively managed and co-ordinated.

People's human rights were protected in line with the Mental Capacity Act (2005).

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People were not always respected and supported by compassionate staff.

People's independence was not always promoted.

People's equality and diversity needs and wishes were not always known.

People's confidential information was not always kept securely.

People's privacy and dignity was not always promoted.

People were involved in decisions relating to their health and social wellbeing.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People told us there was not enough to do, and that they sometimes felt bored.

People's concerns and complaints were listened to and used to help improve the service, but people did not always feel confident about complaining.

People had support plans in place to help ensure they received the care they needed and wanted, but people's future aspirations had not been included and therefore were not met.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

The provider did not always kept up to date with changes in legislation.

The provider had failed to inform the Commission of the registered manager's absence.

People lived in a service which was not effectively assessed or monitored by the provider, to ensure its ongoing safety and quality.

People lived in an environment which did not always have a

positive and inclusive culture.

People, staff and the public were involved in the ongoing development of the service.

People did not live in a service where there was continuous learning taking place to help facilitate improvement

The provider worked in partnership with external agencies in an open and transparent way, for the benefit of people.

Stepping Stones

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.

Consideration was given to the CQC statutory guidance, Registering the Right Support (RRS). RSS underpins the principles of Building the Right Support (BRS). Principles which providers must take into account when developing learning disability services. BRS was written in 2015 by NHS England, and the Association of Directors of Adult Social Services (ADASS) in response to the serious failings which were uncovered at Winterbourne View hospital in 2011.

The inspection took place on 15 and 20 March 2018 and was unannounced and undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We also contacted Healthwatch Plymouth and the local authority quality and service improvement team (QAIT) to ask if they had any feedback about the service. Where feedback was provided, it can be found throughout the inspection report.

During our inspection, we spoke and met with eight people living at the service, five members of care staff, the new deputy manager, acting manager and provider.
We observed care and support in shared areas. We spoke with people in private and looked at four people's care records. We assessed the environment for safety and looked at training records. We also looked at medicine administration records, policy and procedures and the provider's quality assurance checks.

After our inspection we spoke with four relatives to obtain feedback about their loved one's care and raised a safeguarding alert with the local authority safeguarding team in relation to our findings.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2015 we rated this key question as Good, however the rating for this key question has now deteriorated to Requires Improvement.

Overall, risks associated with people's care had been documented to help ensure people's needs were known and met safely by staff. However, risks associated with one person's skin care had recently changed and whilst a new risk plan had been put into place, it was not being correctly followed by staff. For example, one member of staff described how the person should be supported, which was not in line with the person's support plan. There was also no skin monitoring documentation in place to demonstrate the frequency of care intervention and tasks being carried out by staff. This meant the person was at risk of receiving inconsistent care that did not meet their current needs. When we spoke with the acting manager there was confusion about how this person should be supported. The provider requested the acting manager speak with the person's external healthcare professional to clarify the support that should be given and to then re-devise the support plan, as necessary.

People had risk assessments in place relating to aspects of their care, such as their mobility, personal safety and skin care. Staff told us how these helped to meet people's needs. People were encouraged to take control of their own care and support needs, which included taking risks. Risk assessments were in place to help support risk taking, and reduce risks from occurring. For example, people liked to make their own hot drinks and meals in the kitchen, and did their own laundry. People who had behaviour that may challenge staff or others had risk assessments and support plans in place which gave good guidance and direction to staff about how to support the person, whilst taking account of everyone's safety.

People told us there were not always enough staff to meet their needs. Comments included, "They need more staff, there aren't enough", "one staff member doesn't always do medicines on time" and "If I call in the morning when handover is going on I am told to wait". In addition, one person told us, they felt rushed because there were not enough staff. One relative told us they did not feel that people's personal care was always managed effectively, and told us when they arrived sometimes their loved one looked dishevelled. Commenting, "They need more help with their personal care, it all depends who gets [person's name] up". Relatives told us, they did not feel there were enough staff to ensure people were supported with independent living skills and to promote and deliver opportunities for social engagements. For example, one person had a vegetable garden and enjoyed attending to it as the seasons changed, however this had become significantly over grown and needed weeding.

Staff also told us they were unable to effectively promote people's independence, because they did not feel there was enough staff. They told us, "We could do a whole lot more, if we had more staff" and "There aren't enough of us". Staff also told us, how two people's care needs had recently changed, which meant there was now more to do. The provider told us staffing levels were discussed with the acting manager on a weekly basis, however confirmed there was no staffing or dependency level tool in place to help establish if staffing levels met with people's individual needs. The acting manager explained how they were seeking support from the local authority to help review particular care needs within the service, to ensuring staffing

levels were appropriate.

We recommend the provider uses a staffing tool to help ensure staffing levels are suitable to meet people's needs.

Overall, people's medicines were stored and administered safely. People's medicine administration records (MARs) were signed when medicines were given. However, medicines which had been hand written on MARs had not been double signed for accuracy, practice which is not in line with guidelines set out by the National Institute of Clinical Excellence (NICE). People prescribed medicines to be taken when required (PRN), such as paracetamol, did not have support plans in place to provide information to guide staff in their administration. For example, such as what the medicines were for, symptoms to look for, the gap needed between doses or the maximum dose and what alternative actions to try initially.

We were told by the acting manager that staff had received medicines training, but training records could not be found. Staffing competency had been previously assessed in May 2017 by the use of a medicines 'quiz', but the acting manager told us a new, more robust assessment of staff on going skills would be devised. A medicine audit was in place to help monitor medicine practices and identify where improvements were required, however this had not been carried out since September 2017. By the second day of our inspection, the acting manager had completed a medicines audit however, it was not robust and failed to identify MARs had not been doubled signed.

Documentation relating to people's medicines was not always completed in line with best practice guidelines. The system in place to help identify when improvements were required, was not always effective. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People lived in a service where the room temperature was not monitored to ensure it met with people's preferences. Whilst people did not complain to us or staff, during our inspection communal areas and bedrooms were not always warm. One relative told us, that in the winter the heating was set on a timer, which meant it was on in communal areas, but not on in people's bedrooms. They told us this meant their loved one and others felt they were forced to spend more time in the lounge areas, rather than in their own bedrooms. The acting manager told us they would assess the temperature of the environment.

We recommend the provider monitor's the temperature of the environment in line with the guidance set out by the Health and Safety Executive (HSE).

People were assisted with their mobility, by the use of moving and handling equipment, such as hoists. To ensure people's safety, staff had received training. However, one person told us their sling for the hoist cut into their groin and it hurt. They told us staff, were looking into this. However, when we told the acting manager they had not been made aware. The acting manager told us, slings had been 'made to measure', but explained they would retrain staff to ensure the sling was being positioned correctly. Moving and handling equipment was serviced in line with the manufactures guidelines. Overall positive and no recommendation so moved further down.

People told us they felt safe living at the service. Relatives told us they were also confident about the overall safety or their loved one. People were protected from abuse because staff had received safeguarding training and knew what action to take, if they were concerned someone was being abused, mistreated or neglected. Staff had access to the providers safeguarding policy which detailed the local authority safeguarding team contact details. Staff, were recruited safely, and the required checks carried out such as with the disclosure and barring service (DBS). This ensured they were suitable to work with vulnerable

adults.

People were supported to manage their finances. One person's support plan stated, "I have attended the 'learning about money' sessions; I understand there is a procedure in place to protect me from financial abuse". Individual records were kept detailing people's financial transactions, and when people needed specific support to manage their finances, they had support plans in place which they had agreed to.

People lived in an environment which was safe. Fire checks were carried out and people had personal emergency evacuations plans (PEEPs) in place. PEEPs help to provide information to emergency service about how people should be supported in an emergency.

People were protected by infection control practices. Staff had received training in infection control, and put their knowledge into practice. For example, possible infectious outbreaks such as diarrhoea, were handled in line with public health guidelines. Staff wore personal protective equipment (PPE) when appropriate, for example when providing personal care. The kitchens had been awarded five stars by the Environmental Health (EH), the highest rating available.

The provider and acting manager learnt when things went wrong. For example, a recent safeguarding alert had resulted in the acting manager and provider, assessing the staffing skill mix within the team. In addition, the provider and acting manager were responsive to the issues identified during our inspection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2015 we rated this key question as Good, however the rating for this key question has now deteriorated to Requires Improvement.

Staff had undertaken training the provider had deemed as 'mandatory'. Some of which included; moving and handling, infection control, first aid and fire safety. However, training specific to the needs of people living at the service had not been completed. For example, staff had not been trained to support people with physical or learning disabilities or diabetes and cerebral palsy. The acting manager told us that staff had not been trained in how to support people living with a learning disability, because it had never been recognised that people living at the service had such a diagnosis. People living with complex communication needs, relied on staff 'getting to know' them, rather than staff undertaking relevent training. One member of staff told us, "I struggle with [person's name] because I haven't been taught to sign. I think I am doing it right. I struggle so much". In addition, when people had specific clinical needs, there had been no ongoing assessment of staff competency or skills.

People were not always empowered to be independent by the design, adaptation and decoration of the service. The environment was tired. Door frames and walls were scuffed, paint was peeling off walls and a lock on a bathroom did not work. The disabled automatic pads to open lounge doors did not work, and paper towel holders did not always have lids. Lounge areas did not always have sofas or chairs for people to sit on, if they chose to not be in their wheelchair. The environment was not always 'homely' as the provider's polices were displayed on the walls. Relatives told us improvements to the environment were required, commenting "It could be improved… I can't remember the last time it was decorated" and "It could do with a bit of TLC". One relative told us how a toilet seat had been broken for over a year, and another said there was dampness in places.

People had been involved in the design and colour scheme of the service. For example, people had chosen the colour of one of the lounges, helped to 'upcycle' furniture, and one person told us how they had chosen the colour of paint for their bedroom wall. One person told us, the service "Needs a paint job". The provider told us, there was a refurbishment plan in place, with two new kitchens being fitted in the summer. Some bedrooms had also been re-decorated and radiators replaced. Were all the areas above included in the plan and did they say they would deal with these.

People were supported to have a balanced diet, and live a healthy life. The menu was discussed at monthly residents' meetings, to help ensure people's preferences were taken into account. However, food was ordered by the manager, which meant people were not enabled to be involved in the ordering or purchasing of food, which did not promote people's independence. People were encouraged to eat fresh fruit and vegetables and had independent access to drinks and snacks. People helped with the preparation of meals, such as peeling and chopping vegetables.

People's individual communication needs were known by staff, and people's support plans detailed how they preferred and needed to be communicated with. One person's support plan detailed how they used

technology to assist them. People who were unable to write had been given an ink stamp, so they could demonstrate their understanding and involvement in their support plans, and decisions which may affect them. However, the menu was handwritten, which did not take into consideration people's individual communication needs. Signage was not always in place to prompt people to independently locate their bedroom, toilet or dining areas. This demonstrated the provider had not taken account of the Accessible Information Standard (AIS). The AIS is a national requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

We recommend the provider takes account of the Accessible Information Standard (AIS) and uses it to help improve the service.

New staff joining the service received an induction to help introduce them to the provider's policy and procedures. One new staff manager was complimentary about their recent induction telling us, it had been robust and had given them the confidence to start their role. Staff meetings had recently started to take place, but regular one to one supervision of staff practice and appraisals of performance had lapsed, despite this, staff told us they felt supported and could talk to management at any time. The acting manager told us staff supervisions sessions would recommence.

People's health and social care needs were effectively managed and co-ordinated. People's care records detailed how external health and social care professionals were involved in their ongoing care. Pro-active action was taken to involve the right professionals in the review of people's changing care, to help assure they were being supported in the right way. People received annual health checks in line with NHS guidelines.

People's human rights were protected. We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were assessed in line with the MCA to check their ability to consent to their own care and treatment. People's support plans provided good detail about their mental capacity and how this impacted on the decisions they made, for example choosing clothes or managing their finances. The acting manager and staff had a basic understanding of the legislative framework.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in December 2015 we rated this key question as Good, however the rating for this key question has now deteriorated to Requires Improvement.

People were not always respected and supported by compassionate staff. There was limited conversation between people and staff during our inspection. Staff, were observed to be focused on completing tasks, such as washing and cleaning, rather than engaging with people. People were left for periods of time with no engagement. On four occasions people were ignored by staff as they walked through the lounge. One person was left alone in the lounge to find their own entertainment, and was not asked what they would like to do. During an activity, one person struggled to participate. This was not noticed by staff, but by the external activities person, who observed this, and supported the person so they could join in.

Despite staff telling us how much they enjoyed working at the service and how fond they were of the people they supported, the atmosphere in the service was task orientated rather than people ordinated.

The provider's philosophy was based on empowering people to become independent to enable then to move from residential care to living independently. Staff, were called 'facilitators' rather than care staff, so as to help underpin the ethos. However, whilst people were encouraged to clean their own bedrooms, wash their laundry and make meals, they were not assisted with any other aspects of support to help 'facilitate' their independence. People's support plans did not detail the timeframe for them to progress and move from the service. Nor did they detail how this could be achieved. In addition, staff told us they did not always have time to spend with people to enable them to obtain the necessary skills and required confidence, for this to happen.

On one occasion, the promotion of a person's independence was used in an unkind and disrespectful way. For example, drinks were being made for inspectors, but when we asked if one person would like a drink too, we were discouraged, and informed by staff that the person had to make it themselves because they needed to be independent. Whilst the promotion of independence is essential to people's care and support, staff had not taken into account the nicety and kindness of being made a hot drink, when being visited. The acting manager told us they would speak with staff about this.

People's cultural and spiritual needs were not documented to enable them to be known, and therefore met. People had not been asked if they wanted visiting clergy to the service.

People were not always treated with respect, and people's independence was not always supported. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's confidential information was not always kept securely in line with the Data Protection Act 1995. For example, people's support plans were kept in an unlocked cupboard, in an unlocked room. The acting manager told us, they would take immediate action to fit a lock to the cupboard.

People's confidential information was not stored securely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall people's privacy and dignity was promoted. People's support plans provided good detail about how people wanted their privacy and dignity to be maintained. Staff described how they kept people covered up as much as possible, so as not to expose their bodies unnecessarily when assisting people to wash and dress. They also told us, how they closed curtains, and shut and lock doors when providing personal care. One person's support plan detailed how they liked to be assisted to keep their face smooth, however we observed this had not occurred. Staff knocked on people's bedroom doors before entering, but on one occasion during our inspection one member of staff did not, and walked straight into someone's bedroom, as we did due to lack of signage. A relative also told us, how this had occurred when they had visited their loved one. The acting manager told us they would take action to improve signage within the service.

People were involved in decisions relating to their health and social wellbeing. People's records showed how they had discussed aspects of their health with staff and external healthcare professionals. However, one relative told us they were not always kept updated when their loved one had attended healthcare appointments.

People's bedrooms were individually personalised, and their families and friends were welcome to visit at any time.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2015 we rated this key question as Good, however the rating for this key question has now deteriorated to Requires Improvement.

People told us there was not enough to do, and that they sometimes felt bored. Comments included, "I would like to do more things outside", "There are not enough activities, I want to go out more, go to the cinema…do some cooking", "I don't want to sit around and be bored all the time" and "I want more things to do".

Relatives also told us they did not feel there was enough socially for people to do. One relative told us when they had recently visited, they had asked a member of staff what their loved one had done that week, and was told "Nothing, because nothing is going on this week". Relatives expressed that unlike before, staff did not spend one to one time with people. In addition, because the service no longer had a mini bus, it had impacted on people being able to go out. We were told that taxis were used as an alternative, however were costly for people and their families.

There were limited activities for people to join in with, and people were seen most of the day spending time alone or speaking with others living at the service. Some people chose to do colouring, or make cards. One person, who was reading, told us they were bored. On day two of our inspection, a skittles activity took place, hosted by an external person. The event which was held once a fortnight was liked by people, as they were seen to laugh a lot.

People's support plans did not always detail what they socially wanted to do and did not consistently detail what people were achieving on a day to day basis. One relative told us their loved one needed encouragement to be inspired and motivated to do things they enjoyed, but felt staff did not always display this approach. During our inspection we also observed this, when one person took their dominoes out several times to play, but staff did not recognise the person needed and would have benefited from staff interaction.

People's future aspirations had been considered in May 2017. An 'aspirations tree' had been painted on a wall, so people could add their wishes and dreams to it. Staff told us, how some of these had been achieved. For example, one person had purchased a bus pass and another person had gone shopping to purchase something they had wanted. However, continued discussions about people's aims and goals had not taken place or been recorded. This meant people did not have a focus to be motivated by.

People's social care was not designed to meet their needs, wishes and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had support plans in place, which were detailed about how their needs should be met. Support plans were reviewed annually, or as required. Staff told us, overall support plans provided them with the information about how to meet people's needs, but felt some required updating. This was in the process of

taking place. Relatives told us they had not always been involved in the review of their loved one's support plan, to help ensure it met with their needs and wishes. The manager said they would ensure relatives were included in future reviews.

Overall, people's concerns and complaints were listened to and used to help improve the service. For example, one person had complained about their loved one's bedroom, so action had been taken. People had received a copy of the complaints procedure however it was only available in a written format, which meant it may not have been suitable for everyone to understand. Residents' meetings were held so people could share their views openly, however some people told us they were not always confident about complaining, so just put up with things. One relative told us how they had made small comments about things which needed addressing, however no action had been taken, so they had to make a formal complaint.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2015 we rated this key question as Good, however the rating for this key question has now deteriorated to Requires Inadequate.

The service had a registered manager, however they had not been working since September 2017. In their absence, the provider had put an acting manager in charge of the day to day running of the service. A new deputy manager was also in the process of being appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person's'. 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. However, in line with their provider's legal obligations, they had failed to inform the Commission of the registered manager's absence. Following our inspection the provider apologised and promptly submitted the relevant notification. They told us they now understood the process and would ensure this did not happen again.

The provider had met with people and staff to inform them about the interim management arrangements. Overall, people, staff and relatives told us the acting manager had the skills to manage the service. However, one person told us, "We need some new blood trained up" and a relative told us they did not always find the acting manager to be approachable. The acting manager told us, they felt well supported by the provider who visited most months, and was available by phone on a daily basis.

People lived in a service, which was not effectively assessed or monitored by the provider, to ensure its ongoing safety and quality, because the provider was not aware of their governance responsibilities in respect of regulation 17 of the Health and Social Care Act 2008. Therefore, the provider did not have a systematic process to gain oversight and assurances about the quality of the service. As a result of this, the provider had failed to identify, medicine guidance was not always in place, people's support plans were not always accurate, there was not enough staff to meet people's needs and staff had not always received training to support people effectively. In addition, they had not identified improvements which were needed to the environment, people's records not being stored securely, people's privacy and dignity not always being maintained, the limited social opportunities for people, and the culture and leadership of the service. The provider assured us that they would read up about their responsibilities, and would design a governance policy.

Because of the absence of the registered manager, the provider and acting manager were not always able to find certain documents relating to the inspection process, for example medicine training and competency records. The provider told us they had reflected and in the future, there would be more provider involvement and monitoring.

The provider had failed to recognise that people lived in an environment which did not always have a positive and inclusive culture. The atmosphere within the service was based on the completion of tasks, rather than focusing on people. People's comments about the atmosphere included, "It is quiet". Three people told us that staff, were often too busy when they asked for help. The provider's ethos of promoting

people's independence was not embedded into staff practice. Leadership, direction and positive role modelling within the service was absent, which resulted in people not always being empowered and motivated to live fulfilled lives. When people spoke with us to provide their feedback, they were sometimes hesitant, frequently apologised and said "Sorry". Some people did not feel confident to make any complaints. This was not conducive of a safe and inclusive environment and demonstrated that the provider had not given consideration to the CQC statutory guidance, Registering the Right Support (RRS). RSS underpins the principles of Building the Right Support (BRS). Principles which providers must take into account when developing learning disability services. BRS was written in 2015 by NHS England, and the Association of Directors of Adult Social Services (ADASS) in response to the serious failings which were uncovered at Winterbourne View hospital in 2011. Because of this, we raised a safeguarding alert with the local authority adult safeguarding team, to help ensure people were protected.

The registered manager had implemented some quality checks, which included infection control, medicines, and health and safety. However, these had not been completed since the absence of the registered manager, which meant areas requiring improvement had not been identified.

People did not live in a service where there was continuous learning taking place to help facilitate improvement. The acting manager told us they would be attending manager's network meetings with the local authority, to help their increase knowledge and to share ideas. The provider or staff did not attend any other forums or conferences, to help discuss best practice with regard to how to support people effectively and to help ensure the ongoing and sustainably of the service.

The provider's governance framework, to help monitor the management, leadership and culture of the service, as well as the ongoing quality and safety of the care people received was not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, staff and the public were involved in the ongoing development of the service. The provider had met with people and staff recently to discuss the service, and had taken action in response to people's feedback. For example, agreeing to replace kitchens, and changing blinds. One relative told us they would find meetings with the provider useful, so the future vision of the service could be shared.

The provider worked in partnership with external agencies in an open and transparent way, for the benefit of people. For example, a recent safeguarding alert had resulted in the local authority service improvement team being involved within the service, to help ensure lessons had been learnt and improvements made. The acting manager had worked positively with the local authority, and welcomed their feedback to help facilitate improvement.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service user's social care was not designed to meet their needs, wishes and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (1 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service users were not always treated with respect, and people's independence was not always supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Documentation relating to service user's medicines was not always completed in line with best practice guidelines. The system in place to help identify when improvements were required, was not always effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service user's confidential information was not stored securely. The provider's governance framework, to help monitor the management, leadership and culture of the service, as well as the ongoing quality and safety of the care service users received was not effective.